Care Quality Commission

Inspection Evidence Table

Drs Pearce and Trenholm (1-548093087)

Inspection date: 5 March 2020

Date of data download: 27 February 2020

Overall rating: Good

At our previous inspection in December 2018, we rated the practice as requires improvement overall because care and treatment was not provided in a safe way to patients, specified information was not available regarding each person employed and we were not assured about governance systems.

At this inspection we found that our previous concerns had been addressed and we have rated the practice as **good** overall.

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

Safe Rating: Good

At the previous inspection in December 2018 the practice was rated as **requires improvement** for providing safe services because the practice did not have clear systems and processes to keep patients safe, this included aspects of management of health and safety, fire safety and prescription paper security. At this inspection we saw that improvements had been made and we have rated the practice as **Good** for providing safe services.

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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes

Safeguarding	Y/N/Partial
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: • We reviewed the employment records for two staff employed during the last 12 months. The records were complete and showed that appropriate processes had been carried out and they had followed their own recruitment policy and procedure. • At the last inspection, the immunisation status of all practice members had not been recorded. At this inspection the records of all but one staff member contained immunisation details.	

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: August 2018	Yes
There was a record of equipment calibration. Date of last calibration: March 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: February 2020	Yes
There was a log of fire drills. Date of last drill: March 2020	Yes
There was a record of fire alarm checks. Date of last check: March 2020	Yes
There was a record of fire training for staff. Date of last training: January 2020	Yes

There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: January 2020	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: • The practice had an up to date Health and Safety policy and an identified fire safety lead who worked with the fire marshalls. • Checks on alarms were carried out weekly on a Wednesday afternoon and we saw that these were documented.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: February 2020	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: February 2020	Yes

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: February 2020	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes

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.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
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.	Yes

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.80	0.85	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2019 to 30/11/2019) (NHSBSA)	6.3%	4.6%	8.4%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r	4.81	5.93	5.56	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2019 to 30/11/2019) (NHSBSA)				
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2019 to 30/11/2019) (NHSBSA)	2.38	2.36	2.07	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes

Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

- Safe storage of prescriptions had been reviewed since the last inspection. The GPs now have locks on their doors and the nursing team have a locked drawer in their room into which they can store prescription papers while they are out of their room as well as overnight.
- The reception team removed prescriptions every night to a locked room and the door to reception was now locked at all times.
- We looked at 17 PGDs and found that whilst all had been correctly signed, 11 had been incorrectly dated. This was rectified on the day of the inspection. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment
- The practice had also reviewed its correct storage of samples and use of fridge and we saw that the adjustments suggested in the last CQC visit had been implemented.

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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	5
Number of events that required action:	5

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

Event	Specific action taken
There was an unacceptable delay in the time between a prescription being requested and it being issued.	The reasons for the delay were investigated and it was found that the nine day delay in issuing the prescription was caused by several factors all of which had now been rectified by the completion of a new prescribing workflow policy. The patient was contacted and an apology offered. Minutes of the meetings taking place with regard to this were taken and circulated to all relevant parties.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes

Explanation of any answers and additional evidence:

- The practice had a system for recording and acting on alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and we saw examples of actions taken on recent alerts. For example, an audit was undertaken to identify patients who may be taking sodium valproate and to advise them of the possible side effects of this medicine.
- We also saw action that was taken, and examples of letters sent following receipt of another alert regarding the short supply of another medicine used to treat anaphylactic shock.

Effective Rating: Requires Improvement

At the previous inspection in December 2018 the practice was rated as **requires improvement** for providing effective services because the practice did not have good oversight to ensure patients with some long-term conditions and those experiencing poor mental health (including people with dementia) needs were met. We also found that there were gaps in clinical supervision and appraisal of staff.

At this inspection we found that previous concerns had been addressed but the move from the Somerset Practice Quality Scheme (SPQS) to the Quality and Outcomes Framework (QOF) can make it appear that appropriate care and review had not been given to patients. Although this was not the case, evidence was mixed and so we have rated the practice as **requires improvement** for providing effective services.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2019 to 30/11/2019) (NHSBSA)	0.78	0.63	0.72	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.
- 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: Requires Improvement

Findings

- We were not assured that patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. This was due to the low achievement scores for long term conditions indicators.
- 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, but we were not assured that their health needs were being met due to the low achievement scores for long term conditions indicators.
- 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)	59.7%	70.1%	79.3%	Variation (negative)
Exception rate (number of exceptions).	3.0% (12)	8.0%	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)	65.2%	68.5%	78.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.6% (18)	6.8%	9.4%	N/A
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)	31.5%	76.4%	81.3%	Significant Variation (negative)
Exception rate (number of exceptions).	12.9% (51)	11.1%	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)	60.0%	63.5%	75.9%	Variation (negative)
Exception rate (number of exceptions).	1.7% (7)	6.7%	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)	61.3%	74.1%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	2.1% (4)	8.1%	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)	75.5%	78.2%	83.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	0.5% (5)	3.7%	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)	85.2%	88.3%	91.1%	No statistical variation
Exception rate (number of exceptions).	1.5% (2)	5.0%	5.9%	N/A

Any additional evidence or comments

- The surgery had begun taking part in QOF from April 2019 whereas before this time Somerset practices were taking part in a project overseen by NHS England called Somerset Practice Quality Scheme (SPQS), which did not always use QOF codes. We saw evidence to confirm that patient reviews were taking place, but as this was not always recorded using a QOF code, it could lead to low reported achievement figures when compared with local and national QOF averages.
- Because of this the practice achievement figures for the above diabetes, asthma and COPD indicators were below local and national averages. Whilst this was partly due to the practice historically engaging with the Somerset Practice Quality Scheme (SPQS) rather than the Quality Outcomes Framework (QOF) it was also due to the practice not always exception coding patients. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate. This can, therefore, lead to a lower achievement figure as there are more patients in that cohort.
- With the practice now taking part in QOF, the coding had been improved and we looked at a selection of clinical records and saw from unvalidated data that patients were now appropriately excepted in line with national guidance and that achievement figures had improved and were comparable to local averages.

Families, children and young people Population group rating: Good

Findings

- The practice had met the minimum 90% for one of the four childhood immunisation uptake indicators and had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all of the three remaining 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.
- 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)	56	60	93.3%	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)	67	70	95.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	67	70	95.7%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	67	70	95.7%	Met 95% WHO based target

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

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

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	71.5%	N/A	80% Target	Below 80% target

to 64). (Snapshot date: 01/07/2019 to 30/09/2019) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	35.3%	71.7%	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)	60.8%	61.4%	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)	0.0%	45.6%	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)	66.0%	56.6%	53.8%	No statistical variation

Any additional evidence or comments

- The practice had not met the national cervical cancer screening target for the percentage of women eligible for cervical cancer screening at a given point in time.
- The practice was actively trying to improve uptake by sending reminder letters and text messages to eligible women to contact the practice and arrange an appointment for their screening. Screening had also been made available during normal extended hours. Patients were offered appointments at times that were convenient to them and meant they did not have to take time off from work.
- We saw unvalidated data to show that 73% of women aged 25 to 49, and 74% of women aged 50 to 64 had now been appropriately screened.

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.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

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.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	0.0%	51.5%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	9.8%	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)	31.9%	55.4%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	8.5%	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)	0.0%	61.6%	83.6%	Significant Variation (negative)
Exception rate (number of exceptions).	7.1% (3)	6.4%	6.7%	N/A

Any additional evidence or comments

The surgery had begun taking part in QOF from April 2019 whereas before this time Somerset practices were taking part in a project overseen by NHS England called Somerset Practice Quality Scheme (SPQS), which did not always use QOF codes. The move from the Somerset Practice Quality Scheme (SPQS) to the Quality Outcomes Framework (QOF) can make it appear that appropriate care and review had not been given to patients. However:

- We saw evidence to show that review of patients was taking place by long term condition nurses and by the GPs in charge of the patients complex care needs.
- We also saw unverified data to show that achievement figures had improved from those shown above but they were still slightly below local and national averages.
- Registrars, paramedics and nurse practitioners had all been informed of the importance of a holistic review of these patients and to review needs at each and any opportunity.
- The practice had sent information to all patients coded as having dementia, or their carers, making them aware of the Village Agent with contact numbers and a description of the services that could be offered.
- We were told that the surgery had committed to taking part in six health promotion campaigns throughout a twelve 12 month period with a particular emphasis on mental health and dementia issues. The surgery website is being redesigned so that useful links to services for this group of patients can be easily accessed.
- Patients with a new diagnosis of depression were now being appropriately coded and a message alert had been set on the clinical system to remind clinicians that a review after ten was needed to improve follow-up and review progress.
- Patients with mental health issues, who had not attended the surgery and for whom there were no recordings or details of weight, height, blood pressure, smoking or alcohol consumption had been contacted by text message or phone. At least three attemps at contact would be made before the patient would be exception coded.
- The practice had a pharmacist starting within the next two weeks who would provide increased chance of review of patients with dementia and depression as well as performing structured medication reviews.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	304.2	441.3	539.2
Overall QOF score (as a percentage of maximum)	54.4%	78.9%	96.7%
Overall QOF exception reporting (all domains)	2.5%	4.2%	5.9%

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

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

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)	Yes
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.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes

- We saw that patients were signposted and encouraged to purchase medicines available over-the-counter (OTC) from a pharmacy or supermarket for a range of minor health conditions, rather than being given a prescription for these medicines.
- Patients were able to register for online access to appointments, repeat prescription ordering and viewing of their own clinical record.
- The practice website provided a range of patient information related to health promotion.

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)	78.0%	89.8%	95.0%	Significant Variation (negative)
Exception rate (number of exceptions).	1.1% (19)	1.1%	0.8%	N/A

Any additional evidence or comments

- As mentioned previously, the move from the Somerset Practice Quality Scheme (SPQS) to the Quality Outcomes Framework (QOF) can make it appear that appropriate care and review had not been given to patients but we saw evidence to show that the smoking status of this cohort of patients had been recorded and that the figures were comparable to local and national averages.

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.	Yes

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes

- Clinicians we spoke with were able to share examples of where they sought consent and demonstrated that they understood the requirements of legislation and guidance when considering consent and decision making.

Well-led Rating: Good

At the previous inspection in December 2018 the practice was rated as **requires improvement** for providing well-led services because there were gaps in information to show adequate governance systems in place to support that it was a safe and well led service. This included records for recruitment, employment and supervision of staff, maintenance and administration of the service. We also found that the provider had not made the CQC aware of changes to its registration status or made appropriate applications to amend its registration with CQC in a timely way.

At this inspection we found that our previous concerns had been addressed and we have rated the practice as **Good** for providing well-led services.

Leadership capacity and capability

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

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

Explanation of any answers and additional evidence:

- Leaders understood the challenges to providing good quality care and we saw the action they had taken to address them since the last inspection.For example, since the service was last inspected, leaders had identified the practice strengths and areas for improvement and these were shared with us in addition to their business development plan which included consolidating the stable, experienced workforce and a plan to expand the multi-disciplinary team based on patients' needs.
- They advised they were working hard to educate patients of the changes in primary care and communicating the primary care vision.

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.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

Explanation of any answers and additional evidence:

- Leaders told us they had worked hard since the last inspection to encourage a team approach and operated an open-door policy for all staff to approach them at any time.
- The practice had a duty of candour policy in place and leaders told us they promoted an open and honest culture where staff were encouraged to raise any concerns, they had about incidents directly to them. This was reflected in discussions held with staff we spoke with.

Governance arrangements

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

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

Explanation of any answers and additional evidence:

- A range of internal meetings were held each month to discuss and share information with staff. This regular meeting schedule enabled improved communication and a rolling programme was available with evidence of meetings and outcomes documented.
- Since the last inspection, the practice had informed the CQC of changes to its registration details and had provided correct details of current GP partners as well as removing historical partners from the registration. There have been no partnership since the last visit and the CQC also now has up to date e-mail contacts for key staff.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

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

Appropriate and accurate information

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

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

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes
• The practice had access to an external Data Protection Officer via the Clinical Commissioning Group.	

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.	Yes
The practice had an active Patient Participation Group.	Yes

Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: • Leaders told us they continued to be supported by the Friends of Springmead Surgery (FOSS) and were developing a Patient Participation Group (PPG) with the aim of deliverinig a quarterly patient information bulletin.	

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: • The practice had reviewed the results of the annual patient survery and, although an improvement in many areas had been noted, it was also noted that partients wanted more time with their health professionals. With this in mind, a decision had been made to move away from a largely telephone triaged based consultation system to one which provided more 15 minute face to face appointments.	

Examples of continuous learning and improvement
Explanation of any answers and additional evidence: • The practice had taken part in audits which looked at prescribing safety particularly around non-steroidal anti-inflammatory drugs (NSAIDs), such as Lithium and Sodium Valproate. They had also looked at ways to enhance care for end of life patients by improving the completion of treatment escalation plans (TEP). • The nursing team had audited Warfarin prescribing and promoted hand washing techniques by placing information in each clinical room. Warfarin is an anticoagulant (blood thinner) and is used to treat, or prevent, blood clots in veins or arteries, which can reduce the risk of stroke, heart attack, or other serious condition. • We were told that the practice aimed to provide more time for audits when they changed their consultation system in May 2020. This would be achieved by allowing specific time for quality improvement audits in each GP's rota.

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.