Care Quality Commission

Inspection Evidence Table

Maypole Health Centre - Dr Michael (1-9901087863)

Inspection date: 2 June 2021

Date of data download: 19 May 2021

Overall rating: Good

We inspected the practice in September 2019 and rated the practice as requires improvement overall. During this inspection we rated the service as good overall as the practice had made improvements to the areas identified.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe Rating: Good

We inspected the practice in September 2019 and rated it as requires improvement for providing safe services. This was because the practice did not have fully embedded assurance systems and had not proactively identified and managed risks. For example, there were no risk assessments in the absence of some emergency medicines and for products containing hazardous substances. During this inspection we saw that improvements had been made.

Safety systems and processes

The practice had 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.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	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
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:	

Safeguarding	Y/N/Partial
An incident documented by the practice showed that a locum GP raised concerns after a consultation with a child and the lead GP referred the patient to accident and emergency. The accident and emergency team raised a safeguarding alert and the child was taken into care. The practice acknowledged that whilst the locum GP had raised concerns regarding safeguarding of the child the practice had not raised an alert. This did not demonstrate that safeguarding processes were fully developed and embedded. During our previous inspection in September 2019, we identified policies covering adult and child safeguarding however, there were three versions and they lacked clarity as to which version was in use. The policies were generic, not always updated and personalised to the practice to include for example, the names of the safeguarding leads. At this inspection we saw that the policies were specific and tailored to the practice and staff members were able to access them as they were uploaded electronically on the shared drive and GP TeamNet. All staff had completed safeguarding training relevant to their role and a training matrix was in place to ensure management had oversight of training needs. When we inspected the service in September 2019, we saw that staff had received training on chaperoning however, some of the staff we spoke with were not clear on the role of a chaperone. At this inspection staff members, we spoke with were aware of the process for chaperoning and told us that they had completed training. We were told by the practice that all staff had undergone DBS checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We checked three staff files which confirmed this .	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: We reviewed three staff files and we saw that there was evidence of checks undertaken as part of the recruitment process such as references, application forms and proof of identity. During the previous inspection in September 2019 we saw that the vaccination records for two clinical members of staff were not stored by the practice and were provided to us by the individual staff members. During this inspection we saw that relevant immunisation status of staff members were available in staff files. The practice also had a separate folder with immunisation status of all staff members to help them manage this and was planning to upload these electronically to help them manage this more effectively.	

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: January 2020	Y
There was a record of equipment calibration. Date of last calibration: February 2021	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
A fire risk assessment had been completed. Date of completion: April 2021	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: At our previous inspection we saw that a fire risk assessment had been completed with 11 actions identified, although none were assessed as high risk the risk assessment had not been updated to demonstrate progress of the actions. During this inspection we saw that the most recent fire risk assessment had been completed and there were four priority areas that were identified, and these had been actioned by the practice. There was an effective system to monitor training and staff records we looked at confirmed that staff had completed appropriate training. There were data sheets for the control of substance hazardous to health (COSSH), for cleaning products and risk assessments were in place for these. During our previous inspection we saw that there was no risk assessment in place.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 29 April 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 28 April 2021	Y

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: February 2021 (99%)	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:	

At the previous inspection in September 2019, the CQC inspection team identified some areas for improvement in regard to infection prevention and control. At this inspection we found that the practice had made improvements. For example, the practice had started using GP TeamNet over the last 18 months and all policies and procedures were available for staff. There was an infection prevention and control policy that was up to date and personalised to the practice. The infection control audit identified one priority area that had been actioned. Relevant staff files we looked at showed that they had completed relevant training in infection prevention and control.

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 respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information 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
Explanation of any answers and additional evidence: We saw evidence that test results were dealt by the lead GP with assistance from the nurse practitioner. There were relevant protocols in place for the nurse practitioner who met with the GP daily to discuss and review results. There was oversight process where results were audited every 10 days to ensure they were being processed appropriately.	

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) (01/04/2020 to 31/01/2021) (NHS Business Service Authority - NHSBSA)	0.69	0.69	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	7.1%	9.3%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	4.83	5.22	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	116.3‰	108.7‰	127.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.68	0.67	0.66	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

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

Explanation of any answers and additional evidence:

The practice had relevant medicines in stock. There was a system to ensure prescription stationery was kept secure and their use monitored in line with national guidance. Staff were aware of the guidance and understood the purpose. However, the guidance was not always followed or implemented appropriately. We looked at three printers where prescription stationery was kept and identified one printer where whilst it was kept secure, the monitoring system was not implemented effectively. Following the inspection, the practice assured us that they had strengthened their process.

During our previous inspection we saw there were gaps in the medicines required in the event of a medical emergency. The practice had no risk assessments in place that provided a clear rational for the decision to not stock these medicines and how a situation would be managed if it was required. During this inspection we saw that the practice held relevant medicines that would be required in an emergency and did not require risk assessments.

The practice had a process to ensure effective management of patient's prescribed high-risk medicines. Where patients were managed by secondary care and had their blood test in hospital the practice checked to ensure their blood tests were up to date before prescribing the medicine. However, this was not always documented on the patient record system. For example, we saw 13 patients had been prescribed spironolactone (a medication that is primarily used to treat fluid build-up due to heart failure and liver disease) by the practice. Our search indicated that six patients did not have the required blood monitoring. However, when we reviewed these patient records in more detail, we saw that the patients' blood tests were up to date and were undertaken at the hospital. However, the practice had not documented that the bloods had been checked on the patient record system before issuing a repeat

Medicines management	Y/N/Partial
prescription. Following the inspection, the practice told us that going forward they would now be documenting this before issuing any repeat prescription.	

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: 14	Y
Number of events that required action: 14	Y

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

Event	Specific action taken
Patient who overdosed and wanted to see GP	A patient did not want to go to accident and emergency and instead wanted to see the GP. GP immediately arranged to see the patient and arranged an ambulance. The practice team responded adequately to the incident to ensure best outcome for patient.
Locum GP identified potential SG	A locum GP raised concerns with the safeguarding lead following a consultation with them. The lead GP referred the child to accident and emergency. The child was referred to safeguarding by the Accident and Emergency department and the child was taken into care. The practice had identified that whilst concerns were raised, they should have referred this to safeguarding themselves.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts.	

Effective Rating: Good

Effective needs assessment, care and treatment

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

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

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 medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice had a high PCA rate for some patients who had a long term condition of diabetes and atrial fibrillation.
- patients with Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with asthma were offered an asthma management plan.

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. (01/04/2019 to 31/03/2020) (QOF)	75.2%	74.7%	76.6%	No statistical variation
PCA* rate (number of PCAs).	2.6% (9)	8.8%	12.3%	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 (01/04/2019 to 31/03/2020) (QOF)	93.0%	89.1%	89.4%	No statistical variation
PCA rate (number of PCAs).	0.7% (1)	11.6%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	90.1%	80.8%	82.0%	Tending towards variation (positive)
PCA rate (number of PCAs).	0.0% (0)	3.6%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	78.5%	65.0%	66.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	19.0% (35)	13.4%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	77.0%	71.2%	72.4%	No statistical variation
PCA rate (number of PCAs).	2.1% (11)	6.5%	7.1%	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 (01/04/2019 to 31/03/2020) (QOF)	85.1%	88.5%	91.8%	No statistical variation
PCA rate (number of PCAs).	15.2% (12)	5.6%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	89.0%	74.3%	75.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	1.6% (3)	9.7%	10.4%	N/A

Any additional evidence or comments

We spoke with the nurse practitioner and the lead GP and they told us that they did not exception report generally and were unsure why the PCA rate was above local and national averages. The lead GP told us that they reviewed patients with atrial fibrillation. There were 93 patients on the register and 89% of these patients had been treated with anticoagulation drug therapy currently. However, this was unpublished and unverified data.

Families, children and young people Population group rating: Good

Findings

- The practice had met the minimum 90% for five of five childhood immunisation uptake indicators and had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for two of five 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) (01/04/2019 to 31/03/2020) (NHS England)	60	63	95.2%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	52	56	92.9%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	51	56	91.1%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	53	56	94.6%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	43	45	95.6%	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

Any additional evidence or comments

At previous inspection we saw that the practice was slightly below the target range of 90% for the percentage of children aged 1 who had received primary course of immunisation. During this inspection we saw that the practice had worked to improve and had met the WHO target of 95%.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- The practice's uptake for cervical cytology was slightly below the 80% target. However, this represented a small improvement since our previous inspection demonstrating that the practice strived to meet national targets.

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). (Snapshot date: 31/12/2020) (Public Health England)	78.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	72.9%	62.6%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE)	58.9%	N/A	63.8%	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 (01/04/2019 to 31/03/2020) (QoF)	100.0%	94.7%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	61.5%	53.9%	54.2%	No statistical variation

Any additional evidence or comments

During our previous inspection in September 2019 the practice achievement for cervical cytology was 76.9%. During this inspection the practice had achieved a slight improvement to 78.5%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice was transitioning from the pandemic in regards to appointments. Patients were offered face to face same day appointments and longer appointments 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: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- 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 medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- 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 (01/04/2019 to 31/03/2020) (QOF)	91.1%	87.0%	85.4%	No statistical variation
PCA rate (number of PCAs).	1.8% (1)	12.2%	16.6%	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 (01/04/2019 to 31/03/2020) (QOF)	89.7%	82.4%	81.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	6.2%	8.0%	N/A

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)	559	Not Available	533.9
Overall QOF score (as a percentage of maximum)	100%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	4.6%	Not Available	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

The practice had undertaken eight audits in the last 12 months. We saw examples of three cycle audits on antibiotic prescribing. The practice identified that it was above local and national averages for antibiotics in an audit in 2019. A follow up audit in 2020 demonstrated a fall in prescribing and a further 30% reduction was identified in the latest audit in 2021.

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.	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
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

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
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

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 and tackling obesity.	Y

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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: The practice undertook assessment and reviews of patient's capacity to make a decision, which could be done over the phone or from family member.	

Well-led Rating: Good

We inspected the practice in September 2019 and rated the practice as requires improvement for well-led services. This was because there was a lack of effective leadership oversight to ensure good governance. Systems and processes were not always embedded to ensure risks were identified and managed. During this inspection we saw that improvements had been made and we 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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

We spoke with the lead GP and management staff during this inspection. The lead GP stated that since the previous inspection a senior partner had left the practice and another had retired, posing significant challenges. The practice manger was also off long term, which added to the challenge. The lead GP took on the clinical duties and the day to day running of the practice. However, over the last six months a new management team had been put in place and they had implemented significant changes. For example, the practice had started to use GP TeamNet, a web-based platform designed to allow access to information quickly. The practice had also installed a new telephone system allowing monitoring of call traffic to match resources to demand. This allowed the practice to address some of its challenges around access to care.

Staff members spoke positively about some of the changes and told us that leaders were supportive, visible and approachable.

The practice was aware of further challenges such as adjusting to and aligning themselves to the new integrated care systems (ICS). ICSs are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

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 vision and strategy statement that was available to staff. The practice received news that the current building, which was purpose built 25 years previously was subsiding and was to be demolished and a new surgery built. The plan had just been announced and the practice had not discussed the finer details but told us that their priority would be to maintain the quality of care for their patients during this time, where they expected significant disruption.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
From our discussion with the lead GP, management and staff it was clear that the practice had made significant improvements in systems and processes. From our discussion with staff members it was clear that there had been a positive change in the working culture of the practice as staff members stated that they were more happier working at the practice. Management staff told us that staff and patients were happier, the practice had received fewer complaints and there had been a reduction in staff sickness. Staff members spoke positively about the change in culture of the service. The practice manager told us the practice had a more stabilised staffing workforce; staff members got on well and worked well together.	

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

Source	Feedback
Staff feedback	Staff were positive about the service. One staff member said that they were a carer and management were flexible and understanding. They were supported in their role and were provided time away from their regular duties so that they could undertake their lead role.

Governance arrangements

The practice had a new management team to halp develop and embed good governance and to ensure staff were clear on their roles and responsibilities.

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

The practice had improved its governance processes since our previous inspection in September 2019. The practice policies were available in paper format and on an electronic system which were easily accessible to all staff. Discussion with staff showed understanding and awareness of key policies such as safeguarding and whistleblowing.

Previously we identified that not all staff had the relevant training for their role such as safeguarding. At this inspection staff files we reviewed demonstrated that staff were up to date in core training and there was an effective system in place for monitoring staff training and development.

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.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
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

The practice had improved its process to manage risks, issues and performance. At our previous inspection we identified a number of issues such as the lack of risk assessments in the absence of some emergency medicines and the recording of staff vaccinations was not effective. We noted that these had been addressed during this inspection.

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
The practice had a business continuity plan and a buddy site if they were unable to use their premises. All staff worked from the site; clinical staff could work remotely if needed. For example, the GP worked from home when self-isolating. We were told that administration staff were able to work remotely but there was currently no need.	

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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. For example, at our previous inspection in September 2019 we saw that the practice's uptake for cervical screening was similar to the local and national averages however, below the 80% coverage target for the national screening programme. At this inspection we saw that whilst the practice was still below the 80% target, it had made slight improvements.

At the previous inspection we saw that the percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza was 87%, below the 90% minimum target. At this inspection we found that the practice had improved and had achieved the WHO target of 95%.

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

Feedback from Patient Participation Group.

Feedback
We spoke with the chair of the PPG who told us that they had met online during the current pandemic and had their first face to face meeting in April 2021. The PPG chair told us that they normally met every two months. They felt that the practice was open and honest with them and took on board their feedback. For example, members were asked if they would prefer face to face consultations to resume following the easing of Covid-19 restrictions or preferred remote meetings. The PPG chair told us that the practice had taken on the feedback from the PPG to re-introduce face to face meetings/continue with online meetings.

Continuous improvement and innovation

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

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

Examples of continuous learning and improvement
The practice had undertaken a project to improve the uptake of patients who attended for bowel screening. The practice referred patients (pre-Covid-19) for acupuncture and was currently focusing on ensuring improving access to care and disseminating messages regarding good practice around Covid-19.

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.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework).
- ‰ = per thousand.