

# Care Quality Commission

## Inspection Evidence Table

### Dr Barber and Partners (1-569094694)

Inspection date: 5, 6 and 7 December 2022

Date of data download: 24 November 2022

## Overall rating: Good

### Safe

Rating: Good

#### Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However, we identified gaps in staff training.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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:	
Evidence submitted by the practice demonstrated DBS checks were not routinely undertaken for all non-clinical staff. The practice had completed a risk assessment for this stating there was no risk of lone working for these staff. The risk assessment also stated that non-clinical staff were rarely asked to chaperone, however, if they did, they were not left alone with patients at any point. We were advised the practice had made the decision to undertake DBS checks for all newly employed staff and to commence additional DBS checks for non-clinical staff from January 2023.	
We were advised face to face training had been facilitated for staff by the safeguarding lead GP. However, we found that training records to demonstrate clinical and non-clinical staff had completed safeguarding training to the appropriate level were incomplete. Not all staff had received training to the level required as stated in the intercollegiate guidance published by the Royal College of Nursing (RCN)	

Safeguarding	Y/N/Partial
<p>in 2019. The practice was prompt to respond and assigned appropriate training to all staff. We received information from the practice to state all outstanding training would be completed during December 2022.</p> <p>The practice demonstrated a cohesive approach to safeguarding. Through the practice's primary care network (PCN) the practice had access to a dedicated safeguarding administrator who supported all aspects of safeguarding from the maintenance of registers and records through to attendance at meetings when required. There was a safeguarding toolkit and appropriate staff had received training on the toolkit which included an awareness of where to find the practice's own policies and protocols.</p>	

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 UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice utilised a local occupational health service to support with the assessment and vaccination of staff. Records of staff immunity and vaccination status were kept onsite.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 16/09/2022	Y
There was a fire procedure. Date of fire risk assessment: 21/02/2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We noted for many staff fire training had last been updated in 2016. The practice advised all staff would complete update training as a matter of priority during December 2022.</p>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met. However, we identified gaps in staff training records.**

	Y/N/Partial
Staff had received effective training on infection prevention and control (IPC).	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 28 April 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:  During the course of the pandemic, the practice had invested in new clinical flooring to ensure IPC standards were met and risks to patient and staff safety were minimised. The practice advised that there was a plan to replace all carpeted flooring over time. All rooms with carpets were subject to regular professional cleaning and staff ensured treatments were only undertaken in rooms with appropriate clinical flooring in situ.  We reviewed the practice's training matrix and found there were gaps amongst clinical staff for IPC training. We saw that some staff had completed training modules outside of the usual online platform used, for example face to face team training. For some staff, evidence reviewed demonstrated their training to be several years old. We were advised the completion of up to date training would be prioritised for completion during December 2022.	

## 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
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence: Staff we spoke with reflected on training in emergency procedures which incorporated both annual face-to-face training and online training. Whilst we found there were gaps in the practice's records for online training, evidence was submitted to support that face to face training had been completed in November 2022 with catch up training booked for 10 January 2023 for staff still outstanding.	

## 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. <sup>1</sup>	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: <sup>1</sup> Review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.	

## Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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) (01/10/2021 to 30/09/2022) (NHSBSA)	1.04	0.86	0.82	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). (01/10/2021 to 30/09/2022) (NHSBSA)	6.1%	7.9%	8.5%	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	5.60	5.12	5.28	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
infection (01/04/2022 to 30/09/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	130.8‰	130.8‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.30	0.59	0.58	Tending towards variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	9.8‰	7.7‰	6.8‰	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.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of 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. <sup>1</sup>	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. <sup>2</sup>	Y
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 and Improvement 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.	Na
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

Medicines management	Y/N/Partial
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 UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>A review of 32 clinical records, identified by the clinical search, for patients taking a medicine to treat rheumatoid arthritis, showed that three patients appeared to have not received appropriate monitoring. Further investigation found appropriate action was being taken within secondary care settings to support identified patients. For example, we identified patients being supported by a local hospital clinic.</p>	

### 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:	4
Number of events that required action:	4

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

Event	Specific action taken
Incorrect patient booked for appointment. Error was noticed before any treatment provided.	The practice investigated the incident and procedures to prevent the risk of recurrence were reinforced with staff. Additional action was taken to highlight the risk and reduce the chances of recurrence.
Potential data protection information breach.	The practice was prompt to respond to concerns raised and undertook a full investigation. Affected persons were kept informed and actions were taken to strengthen policies and procedures. Staff received training and records of steps taken were available for review.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was evidence to support a systematic approach to responding to safety alerts and recording of actions taken. We reviewed action taken in response to a safety alert concerning teratogenic medicines. Records reviewed demonstrated appropriate action had been taken, included changing of medicines and updating of patients' records with warning information as required.</p>	

## Effective

## Rating: Good

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

### 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. <sup>1</sup>	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y

### Effective care for the practice population

Findings
<ul style="list-style-type: none"><li>• 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.</li><li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li><li>• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li><li>• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li><li>• 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.</li><li>• All patients with a learning disability were offered an annual health check.</li><li>• The practice undertook regular audits of patients receiving end of life care. End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.</li><li>• The practice worked with the local collaborative care team (CCT) to support vulnerable patients. There was a dedicated administrator from the practice whom patients could access directly</li></ul>



through a bypass telephone number, ensuring they received timely and appropriate support when needed.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice employed a community advanced nurse practitioner who supported housebound patients and those living in two local care homes. Additional GP support was available to these patients if needed.

## Management of people with long term conditions

### Findings

- Remote clinical searches found practice systems for supporting patients with long term conditions were operating effectively. For example, we found there were 713 asthmatic patients registered with the practice. Of these 44 had received two or more courses of steroids in the preceding 12 months. A random sample of five of these patients were reviewed in detail and no concerns were identified.
- We found evidence to demonstrate the practice was supporting patients at risk of developing long term conditions through effective monitoring and treatment.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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	148	150	98.7%	Met 95% WHO based target

doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	126	133	94.7%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	126	133	94.7%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	126	133	94.7%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	126	140	90.0%	Met 90% minimum

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

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (30/06/2022 to 30/06/2022) (UKHSA)	76.2%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	47.1%	56.8%	55.4%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	81.3%	69.1%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	68.7%	64.4%	66.8%	N/A

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

### Any additional evidence or comments

The practice was aware that it had not met the 80% target for cervical screening and advised there was a proportion of patients who had historically stated they struggled to attend due to working hours. Practice leaders advised that with the additional availability of appointments in the evening and weekends, through the extended access service they expected to see improved uptake amongst these patients. In addition, a dedicated nurse administrator ran regular searches and contacted patients outstanding their cervical screening to encourage uptake.

### 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.**

	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

The practice did not submit evidence to demonstrate they were undertaking regular two cycle audits to monitor improvement activity. However, they did provide supporting evidence to demonstrate that they were undertaking regular audits and reviews, taking action where needed, particularly in relation to medicines safety. We received a report from the clinical pharmacist which demonstrated protocols and actions taken to monitor patient safety with regard to medicines. For example, action was taken to change medicines prescribed where potential contraindications had been identified to ensure patients were not at risk.

### Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, we identified gaps in staff training records.**

	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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>We found multiple gaps in staff training records including but not limited to safeguarding, infection control, fire safety and equality and diversity.</p> <p>Staff employed in advanced clinical practice advised they were well supported. One of the GPs undertook regular audits of their work and there was allocated time each day for these staff to discuss their patients with GPs. In addition, staff advised they had access to GP support at all times if needed.</p>	

### 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
<p>Explanation of any answers and additional evidence:</p> <p>Patients were able to access the local smoking cessation service via self-referral.</p> <p>The practice had access to the local collaborative care team (CCT) which supported vulnerable patients, including those requiring end of life care. In addition, the practice employed an advanced nurse practitioner to provide care in the community. They undertook home visits and liaised with the CCT where necessary to ensure patients received the appropriate care. The community nurse also</p>	

supported the two local care homes assigned to the practice acting as a point of contact and supporting with regular ward rounds and care as required.

### 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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Y
Explanation of any answers and additional evidence: As part of our inspection, we reviewed DNACPR decisions made within the last 12 months. We undertook a random review of five records and saw that they were all detailed and comprehensive. We identified that decision forms had been retained and signed by an appropriate clinician. Care notes outlined how the decision had been discussed with patients, and how an assessment of the patient's mental capacity had been undertaken. A flag had also been added to patient's electronic records to indicate to staff that a DNACPR decision was in place	

## Caring

**Rating: Good**

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Patient feedback	
Source	Feedback
Patient feedback collected by the practice.	The practice provided evidence of patient compliments they had received. Patients complimented the approach of staff, noted improvements in provision and expressed gratitude for the quality of care received.
Patient feedback collected during the inspection	During our inspection, we spoke with a patient who advised they were satisfied with the service provided and that they were treated with kindness, dignity and respect from all practice staff. They advised they were always able to get an appointment if needed and felt the support available to carers was invaluable.
Patient feedback on the NHS website (formally NHS Choices).	There were three comments left from patients in the 12 months preceding our inspection. Patients commented positively on staff attitude, access and timely support received.

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	82.4%	82.7%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	84.0%	81.7%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	94.7%	91.4%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	75.6%	69.7%	72.4%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Any additional evidence
The practice collated feedback from patients through a variety of channels, including a patient feedback box in reception, complaints and compliments. At the time of our inspection, the practice was not participating in the NHS Friends and Family Test (FFT). The FFT is a national survey undertaken to gauge how likely patients are to recommend the service to friends or family in the local area. Staff advised they were in the process of restarting the FFT using a SMS text message service.

## Involvement in decisions about care and treatment

### Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Patients had access to a social prescriber who was able to support patients with additional non-clinical needs. Staff advised uptake for the social prescribing service had been high and feedback received from patients was positive.	

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	88.4%	88.4%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y



Carers	Narrative
Percentage and number of carers identified.	In December 2022, the practice patient population list was 12.964. The practice had identified 666 patients as carers; this amounted to 5.1% of the practice population.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>• The practice had received the Gold Standard Carers award from the local authority for work it did to support carers.</li> <li>• There was a dedicated carer's champion who supported carers.</li> <li>• The practice's computer system alerted staff if a patient was a carer.</li> <li>• New patient registration forms included information to highlight if patients had caring responsibilities.</li> <li>• The register was validated annually and all carers were sent a carers information pack which included information on local support services</li> </ul>
How the practice supported recently bereaved patients.	Staff told us that if families had suffered bereavement, the practice contacted them. Further advice was also offered through a bereavement pack which was sent to families. The pack provided information on actions to take following a death as well as information on local support groups.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: The practice had installed signage at reception to improve privacy at the reception desk.	

# Responsive

Rating: Good

## Responding to and meeting people's needs

### The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.00am to 6.30pm
Tuesday	8.00am to 6.30pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 6.30pm
Friday	8.00am to 6.30pm
Appointments available:	
Monday	8.30am to 12.30pm 2.30pm to 6.00pm
Tuesday	8.30am to 12.30pm 2.30pm to 6.00pm
Wednesday	8.30am to 12.30pm 2.30pm to 6.00pm
Thursday	8.30am to 12.30pm 2.30pm to 6.00pm
Friday	8.30am to 12.30pm 2.30pm to 6.00pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"><li>• Patients had a named GP who supported them in whatever setting they lived.</li><li>• The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.</li><li>• The practice employed its own community advanced nurse practitioner to support patients at home or in local care homes.</li><li>• The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. This included working with the local collaborative care team (CCT) to provide effective care for vulnerable patients</li><li>• All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.</li></ul>

- Pre-bookable appointments were also available to all patients at the primary care network (PCN) hub location within the area. Appointments were available weekday evenings from 6.30pm to 8pm and on Saturdays from 8.30am to 5.00pm.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## Access to the service

### People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patients were able to book appointments in person, by telephone or online (for some appointments only). Patient satisfaction with access to the service was good. Patients were able to choose between face- to-face appointments or telephone/virtual consultations. The practice reported it had been quick to return to face-to-face appointments during the pandemic, as soon as it was safe to do so. On the day of our inspection, we saw same day appointments were available for those requiring urgent care. Pre bookable appointments for routine care were available the following day.</p>	

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2022 to 30/04/2022)	62.8%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	64.5%	55.4%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	56.8%	52.5%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	70.0%	72.2%	71.9%	No statistical variation

## Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	9
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: Staff advised that whilst the number of complaints received had increased over the pandemic the number of formal written complaints remained low. They aligned this to their commitment to, where possible, resolving patient dissatisfaction and queries promptly through discussions with the practice manager or reception supervisor.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint regarding quality of care and delays	The practice discussed the complaint in a formal meeting and an assessment was undertaken. The complainant received a written response from the practice. Communications we reviewed were sent within the practice's complaints handling timeframes as stated in the complaints policy.
Patient complaint regarding incorrect contact details	The practice responded to the patient following a thorough investigation to offer assurance the details held were correct.

## Well-led

## Rating: Requires Improvement

We have rated the practice as requires improvement for providing Well-Led services because:

- Staff in leadership roles were unable to demonstrate that they were effectively monitoring training needs.
- We found multiple gaps in staff training records including but not limited to safeguarding, infection control, fire safety and equality and diversity. Practice leaders advised all outstanding mandatory training would be completed during December 2022.

### 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: Discussions with the leadership team highlighted a clear understanding of future challenges to quality and sustainability, particularly with regard to recruitment of clinical staff. They advised of actions taken to reduce risks. For example, one of the GPs was almost qualified as a GP trainer which they anticipated would improve recruitment of clinicians in the future. In addition, the practice was proactive in supporting staff to upskill and develop their careers to provide opportunities for staff but also secure future service delivery for patients.	

### Vision and strategy

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

	Y/N/Partial
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: Staff we spoke with spoke of a shared aim to keep patients at the centre of their work and ensure they provide the highest quality care and service to patients.	

## 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 had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We noted many staff had worked at the practice for prolonged periods of time. Those we spoke with advised this was due to the high levels of job satisfaction they experienced and their enjoyment in working at the practice.</p> <p>Training records reviewed showed not all clinical staff had completed equality and diversity training. In addition, some non-clinical staff had not completed refresher training for up to 6 years. The practice advised all outstanding training would be during December 2022.</p>	

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

Source	Feedback
Staff feedback	Feedback from staff who worked for the service was positive. Staff reported a good working environment and a positive culture. Staff described leaders and managers as approachable and supportive, and felt comfortable in raising any concerns without fear of retribution.

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Evidence provided and discussions with staff demonstrated there were appropriate leads for specific roles and all staff were aware of who to contact.</p>	

## Managing risks, issues and performance

**There were clear and effective processes for managing risks, issues and performance. However, we found gaps in staff training records.**

	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.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: Staff in leadership roles were unable to demonstrate that they were effectively monitoring training needs. We found multiple gaps in staff training records including but not limited to safeguarding, infection control, fire safety and equality and diversity. Some training modules had not been refreshed for several years and for others evidence of face to face training undertaken was not reflected in the training matrix. Training records to demonstrate clinical and non-clinical staff had completed safeguarding training to the appropriate level were incomplete. Not all staff had received training to the level required as stated in the intercollegiate guidance published by the Royal College of Nursing (RCN) in 2019. The practice was prompt to respond and assigned appropriate training to all staff. During our inspection, the practice reviewed its online training system settings, making some training modules mandatory and requiring regular refresher training. Practice leaders advised all outstanding mandatory training would be completed during December 2022.	

## 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
Staff whose responsibilities included making statutory notifications understood what this entailed.	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.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: Remote telephone and video consultations took place within closed clinic rooms to ensure patient confidentiality was maintained.	

## Engagement with patients, the public, staff and external partners

### The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: The practice had developed good working relationships with its patients, the wider local community, and other stakeholders. Staff and managers worked to deliver and adapt their service to ensure it continued to meet the needs of its patients. Leaders spoke positively of working relations with other local practices and collaborative working as part of the primary care network (PCN).	

Feedback from Patient Participation Group.

### Feedback

We spoke with a member of the PPG who advised they felt valued by the practice and that meetings were productive and engaging. Meetings were facilitated approximately every three months either face-to-face or virtually. We were informed the practice was open and honest with the PPG and keen to gather feedback and act on any identified concerns.

### 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.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: There was an established meeting structure that allowed for the sharing of learning from events, complaints and audits, to ensure changes were proactively embedded. The practice undertook regular audits and reviews to ensure effective medicines management and patient safety in relation to medicines.  We saw there were dedicated administrative leads for various areas, such as nursing, health and safety, safeguarding and reception which supported effective management and oversight of these areas.  The practice took a proactive approach to feedback received during the course of the inspection, regarding gaps in staff training records. Prompt action was taken to ensure all staff completed mandatory training during December 2022.	

## 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 practice's 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> 1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.
- UKHSA:** UK Health and Security Agency.
- 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.
- %** = per thousand.