

# Care Quality Commission

## Inspection Evidence Table

### The Derby Road Practice (1-8423809281)

**Inspection date: 29 September 2022**

**Date of data download: 19 September 2022**

The Derby Road Practice is part of Suffolk Primary Care which consisted of a partnership of 9 GP surgeries covering a population of 115,000 patients across Suffolk. There were 28 GP partners and around 500 staff who worked across the practices. Whilst each practice retained oversight of their demographics and patients' needs and priorities, there was a centralised head office which provided a single governance structure with clear engagement from all partners. There were key roles such as a management board consisting of a chair, medical directors, business director and finance directors. In addition, there were other teams such as an executive team with delegated decision-making authorisations, information governance and Information Technology (IT), human resources (HR), finance, research estates, procurement complaints and governance. There were clinical and administration teams who managed some functions such as patient safety alerts and the quality audit programme. In addition, there were various manager and lead roles including head of operations, website management and business intelligence. Many of the centralised functions and teams supported the practices with policies and procedures, and there was additional staff support for managing surges of patient demand such as medicines management. In addition, there was background support services such as recalls for patients with long term conditions and follow up. Other services to practices included maintenance of estates and properties, human resources (HR), safety of equipment, and risk assessments. There was also oversight and central management of teams such as the pharmacy team consisting of pharmacists and pharmacy technicians (some of these are also based in practice) and physiotherapists who also worked as part of the primary care network. The provider and practice demonstrated clear and cohesive joint working and sharing of resources in particular different staff skill mixes including clinical and non-clinical staff.

Within the Suffolk Primary Care organisation there were ten approved GP trainers and a further 6 associate trainers. Across the practices there was support and teaching/supervision and oversight for the employed clinical staff such as non-medical prescribers as well as GP registrars, foundation year doctors and medical students, nursing and paramedic training.

As part of this inspection we visited both The Derby Road Practice and the branch site of Pinewood Surgery.

**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.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes <sup>1</sup>
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Suffolk Primary Care (SPC) had an overall safeguarding child and adult lead. All policies and procedures and structural flow charts for the safe management of cases were overseen by the lead. We saw evidence of shared learning from all the practices within SPC and also wider learning such as national case conferences. At a practice level, we saw that there was a GP lead and administrator who worked closely with the practice staff to ensure patients were kept safe from harm. Regular multi-disciplinary team meetings were held, and registers were kept up to date.</p> <p>1. The practice demonstrated that staff were trained in child protection and they had clear oversight of the process. They told us that most non-clinical staff were trained to level one safeguarding and the practice was working toward these staff being trained to level two. All clinical staff were trained to level three. Staff we spoke with gave us examples of where safeguarding concerns had been reported and actions taken to protect patients.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Suffolk Primary Care (SPC) had invested in a specialised team to manage the human resources needs of all their practices. The practice was actively involved in identifying any staffing needs and was also part of the recruitment process. The centralised office managed all the required checks and documentation, including applying for occupational health clearance and requesting the correct level of DBS check. Since the development of the HR office, all documentation was managed electronically. SPC were in the process of adding all documentation from staff employed by the practice before November 2021. We reviewed 8 files in total and found all the necessary documentation was in place, although some was held electronically, and some was still in paper form within the practice.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes <sup>1</sup>
Date of last assessment for both sites August 2022.	

There was a fire procedure.	Yes
Date of fire risk assessment: For both sites November 2021	Yes <sup>2</sup>
Actions from fire risk assessment were identified and completed.	
Explanation of any answers and additional evidence: 1&2 We saw from the practice's electronic records that both the practice and the centralised office had clear oversight to manage all checks relating to health and safety including fire safety. We found clear evidence of roles and responsibilities and checks that actions were taken. We found risk assessments had been completed including those relating to fire safety and equipment, management of asbestos and legionella and calibration of equipment. Regular servicing checks were programmed for both teams to see and ensure completion including receipt of reports. Any actions taken were clearly documented, for example a discussion with the cleaning company regarding control of substances hazardous to health (COHSS) which ensured that there was clear information regarding products they may use and any associated risks.	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: September 2022	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: We found there was clear oversight between the teams for the management of infection prevention and control (IPC). The practice had joint leads for IPC and in addition, worked with the local ICB and primary care network leads to share any changes in guidelines, concerns, learning or good practice. There were clear processes for the cleaning of equipment and other quality checks such as hand hygiene.	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
Explanation of any answers and additional evidence:	

The provider and staff told us they were able to manage staff resources well to meet the challenges the COVID-19 pandemic had posed and the issues that were ongoing. For example, during the pandemic the practice found they did not have enough staff to be able to provide safe services. As part of the bigger organisation of SPC, staff from other practice locations or the centralised office were able to provide those services. For example, GPs and nurses were able to manage patients' needs by remote calls and arrange for any face to face appointments appropriately. SPC and the practice were able to gain use of laptops for staff who were able to work from home, such as home answering telephones. The practice was proactive in making changes to help keep staff well and prevent absences, for example by using one practice site where low risk patients were seen, and remote services were offered during the COVID-19 pandemic. This site was staffed by staff members who were identified as more vulnerable. This allowed the less vulnerable staff to manage the 'hot' site for patients who were more unwell. All staff were provided with personal equipment such as own telephone headsets which they cleaned and kept with them, to prevent any infections spreading through the sharing of essential equipment.

During our inspection we saw a comprehensive and clear set of information to guide care navigators in dealing with calls, signposting to other professionals and other useful information. This volume of essential information was available in easy to use files and electronically. This encyclopedia of information was being shared across the wider SPC practices. Staff told us it was very informative and written in language which was easy to read and understand .

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

## 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) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.90	0.90	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). (01/07/2021 to 30/06/2022) (NHSBSA)	10.5%	8.0%	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 infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.38	5.93	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	171.1‰	154.2‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.38	0.51	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	8.6‰	8.2‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes <sup>1</sup>
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes

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.	Yes <sup>2</sup>
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ol style="list-style-type: none"> <li>1. We found the practice had a system to ensure structured medicine reviews were carried out for patients. During the COVID-19 pandemic, a backlog of structured medicines reviews had developed, however, they had a clear action plan to address this. In the past 12 months 73% of patients aged 65 and over and on 4 or more medicines had received a structured medicines review.</li> <li>2. As part of our inspection we used a suite of clinical searches and reviewed patient records. The practice and the centralised SPC team managed the monitoring of patients prescribed high risk medicines. For example, we found: <ul style="list-style-type: none"> <li>• 57 patients taking a high-risk medicine (methotrexate) and all had received the required monitoring.</li> <li>• 30 patients taking a high-risk medicine (Azathioprine) and all had received the required monitoring.</li> <li>• 19 patients taking a high-risk medicine (Lithium) and all had received the required monitoring.</li> <li>• 1735 patients taking an ACE inhibitor or Angiotensin II receptor blocker and 134 were identified as not having received the required monitoring. We looked at 5 records and found three patients who had not been prescribed the medicine in the past 12 months and who were possibly no longer a patient at the practice. We found 2 patients who were overdue for their monitoring yet had been prescribed the medicine without actioning the overdue monitoring needs. The practice told us they were aware of the patients overdue their monitoring and had considered reducing their prescription quantity to encourage attendance. The provider (SPC) had monitoring searches undertaken regularly to ensure all patients where overdue monitoring was identified were managed appropriately and with clinical oversight. The practice was working towards obtaining physical data and information such as blood pressure and weight to update the patient's records. We saw, in the practice, they had various methods of increasing the ways in which they could obtain updated blood pressure readings. This included the loaning of blood pressure monitors (these were all in clear boxes for easy identification and clear infection prevention cleaning regimes) and contacting patients for their weights. There was a suitable area in the waiting room for patients to use the practice waiting room blood pressure monitor and weighing scales.</li> </ul> </li> </ol>	



## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	16
Number of events that required action:	16
Explanation of any answers and additional evidence: We saw there was a clear process for the practice to identify, report and share learning from events however minor, with their staff and across the wider organisation. The practice used an electronic system for reporting incidents and staff we spoke with told us they knew how to use this and found it easy. They told us there was an open and supportive culture in the practice and organisation to report any issues they may have been involved in or noticed during their work. Learning from all practices was discussed at meetings and minutes were available to all staff. Staff told us the practice and organisation made changes or improvements when needed.	

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

Event	Specific action taken
Information Governance Patient had access to online records and identified some correspondence that was not theirs. Although the patient had given this as informal feedback and did not want to make a formal complaint the practice raised it as both a significant event and a complaint.	The practice removed the information and apologised to the patient and identified the error which included an error by secondary care. They contacted and passed the information onto the correct practice and although the letter was routine, they ensured the correct patient received the information

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	

We found there was a joint system with clear roles and responsibilities between the centralised SPC function team and the practice for managing safety alerts. The provider's centralised function team had a clinical lead and an administration lead. Other team members included pharmacists and administrators to ensure alerts were correctly managed during periods of planned or unplanned absence of lead staff. Within the practice the practice manager and clinical lead also managed alerts. All information was easily available to all staff via the electronic intranet system. Where immediate action was needed in relation to a safety alert affecting patients, the centralised office usually undertook a clinical search for the patients across all the practices and addressed the immediate need. Where information was not immediate but required actions including the review of patients taking medicines or making patients aware of possible risks, the information was cascaded to the practice for them to action. Clear audit trails were kept and monitored to ensure all actions were completed in a timely manner. GPs and clinical staff with prescribing qualifications were kept up to date with new guidelines and requirements through the information held on the team intranet and through clinical meetings which were regularly held.

Although we found most alerts had been monitored, we found 9 patients who were identified as at potential risk from taking a combination of medicines where the risk was increased when the patient was aged over 65 years. We reviewed 5 records and found there was no evidence that the risks had been discussed with the patients despite the medicines being prescribed. We discussed this with the practice who explained they believed the oversight was a result of using an increased number of locums during the COVID-19 pandemic. The practice took immediate action to review all 9 patients and although they told us they were using less locums, they increased their oversight of the quality of their work.



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

### 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. The practice provided data which showed 3718 patients were eligible and 1073 were invited in the past 12 months and the practice had completed 244 checks.</li><li>• All patients with a learning disability were offered an annual health check. The practice had 123 patients with a learning disability on their register. In the past 12 months, the practice had invited</li></ul>

all of these patients for a review and had completed full annual reviews on 64% of these patients. We discussed the service the practice offered to patients with a learning disability and spoke with the staff member who was the clinical lead. They told us and we saw from records, that the practice took a considered approach to this vulnerable group of patients and worked with the individuals to complete these health checks. For example, we saw how a staff member had met weekly, on the same day, time and in the same room in order to gain the trust of a vulnerable patient who had been too anxious previously to attend any appointments. These visits had yet to progress to being able to undertake some of the required physical monitoring checks. However, the clinician, had progressed the patient's ability to attend the practice and gained their confidence. The practice and staff were proud of this personalised approach for their patients.

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Feedback we had from representatives from local care homes was positive about the end of life care provided by the practice staff.
- 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 worked closely with link workers from community teams to ensure patients were well supported. The practice was working on their accreditation to be a dementia friendly practice.
- The practice had, at short notice, responded to the needs of a vulnerable group of patients. Approximately 60 refugees were housed in the local area, some of these patients were new to the country and required registration to the health system. They worked with the outreach team to provide medical assessments and immediate and ongoing care plans. The practice identified additional clinical resources to be able to manage this population of complex and much unmet need. They had access to interpreters to ensure information that was shared between the patient and the clinician was accurate. The practice worked closely with other health professionals such as children services and voluntary agencies such as the local church. This work is continuing however the challenges remained constant, as the population changes at short notice with patients leaving and new refugees being housed.

## Management of people with long term conditions

### Findings

- The practice had been working and redesigning their recall system and approach to monitoring to help patients manage their long-term conditions. The practice had recruited additional staff such as health care assistants (HCA's) to aid the care and effectiveness of regular follow up and monitoring. The practice had developed a team approach utilising the skills of GPs, nurses, HCA and pharmacists. Additional staff such as care navigators and social prescribers were also used. The practice told us that this multi-disciplinary approach to supporting and managing patients with a long-term condition ensured all patients' conditions were monitored at the same time and the patient received personalised care and care planning.
- 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 chronic kidney disease and hypertension. The practice recognised an increase in the number of patients diagnosed with heart failure (30 new cases in the past 12 months), a number of whom were identified through the process of all patients having their pulse checked at any opportunity. They told us they had also identified 214 new cases of patients with hypertension.
- Through our clinical searches we identified 5 patients with a potential missed diagnosis of diabetes. We reviewed all 5 records and found all 5 patients required a review. These patients had been missed through inconsistent coding. We discussed these patients with the practice, and they took immediate action. During our discussion the practice told us that since coming out of the pandemic they have diagnosed 146 new cases of diabetes and 28 cases of prediabetes and added to their action plan to review the coding of records.
- 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 doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	180	186	96.8%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	183	190	96.3%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	184	190	96.8%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	184	190	96.8%	Met 95% WHO based target

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)	240	255	94.1%	Met 90% minimum
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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). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	77.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	71.0%	67.4%	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)	68.9%	70.2%	66.8%	N/A
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)	57.6%	58.7%	55.4%	No statistical variation

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 of the lower than 80% target performance for patients screened for cervical cancer. The practice continued to offer appointments at times that were acceptable to patients and appointments were also available through the extended hours service of Suffolk GP+.

#### 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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes

The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
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Example of audits/quality improvement work undertaken in the past 12 months by the practice and shared with the wider organisation of SPC.

Audit relating to Oestrogen only HRT in patients with an intact uterus.

Patients taking Oestrogen only HRT in patients with an intact uterus and where there was no coding, they had a levonorgestrel uterine system (IUD) in place.

- The practice reviewed the identified patients and found the coding of their medical records was not accurate.
- They also identified that some patients had been prescribed hormone therapy which was not licensed for first line HRT treatment.
- They also identified that some patients (including those who had an IUD inserted before they joined the practice had been advised that the IUD would remain in place for 5 years (the guideline is this should be 4 years when used in relation to HRT).
- All patients were contacted and the options for replacement or other methods were discussed and agreed.
- Learning was shared across the practice and wider SPC network, and regular audit cycles were performed to continue the 100% compliance with coding and recall dates.

Service impact on reducing hospital readmission.

- A member of the pharmacist team was giving some medicines advice to a patient who had been discharged from hospital 4 months earlier with an unrelated problem. During the review of the patients' concerns and the medicines they were prescribed, the patient shared that they had not had a follow up with the hospital as had been planned. During discussion it was clear that the patient was not fully aware of why they were taking the medicines prescribed on their discharge or for how long they should take them. The staff member contacted the hospital to check the medicine regime and during this call it was identified that there was a potential prescribing /diagnosis error. The staff member ensured all was correct and that the patient was fully aware of their medicines and their use. Learning was shared across the practice and organisation to highlight the need to confirm the rationale/indications for taking medicines before adding to the repeat prescribing template.

Other audits undertaken included those for medicines and condition management and non-clinical work such as coding and summarising medical records, patient workflow and pathology filing.

### Any additional evidence or comments

The centralised office managed a significant programme of quality assurance across all of the practices. A programme of 81 audits was maintained and the practice had been involved in these. Throughout the year, the practice was provided with performance data for their practice across all of the quality indicators that the provider had identified, including medicines and disease monitoring. Other audits were undertaken for non-clinical work such as summarising and patient correspondence. The practice reflected on those results and each quarter undertook up to 5 audits reviewing areas where they were identified as needing improvement. The results of the audits were reviewed by the clinical governance team within SPC. They ensured any patients excluded from the criteria for reasons such as on maximum therapy, dissent to attended appointments had been clinically reviewed and excluded appropriately. The practice

was only able to exclude any patient for that annual audit only, this ensured all patients were reviewed when the audit was undertaken again.

The practice was part of a group audit which had resulted in the practice performance in monitoring high risk medicines had improved significantly. From our searches we saw that patients were monitored safely and effectively.

We discuss this with the practice, and they told us this approach was supportive in them being able to address the areas of need more effectively. They reported that by choosing the review themselves and undertaking the audit they were able to ensure it addressed the need of their patients and any learning outcomes identified for the practice staff.

## Effective staffing

**The practice was able to demonstrate 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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: The provider and the practice showed clear oversight of the training and development of staff. We found training the practice deemed mandatory was managed and staff were given information when training was due. Opportunities for developments were discussed and given to staff for example support given to clinical staff to gain prescribing qualifications and for non-clinical staff to take managerial roles within the practice or in the wider organisation. Staff told us they had easy access to their managers and lead GP in the practice and there was an open culture towards learning, support and development. Where training was overdue, training reminders were sent to staff and time was set aside for it to be completed. Most of the training was via an electronic system but more face to face training was planned. The practice utilised skills available in the practice to conduct in house training such as good hand washing technique.	

## 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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: Through the provider and PCN, the practice had access to a health and well-being coach. Staff we spoke with told us they were able to refer patients to this coach to gain support and to be signposted to other support agencies such as smoking cessation services. They told us this was a positive experience for patients who were able to discuss, in longer appointments, their well-being and their engagement/motivation in making changes to manage their own health.	

## Consent to care and treatment

### The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Yes
Explanation of any answers and additional evidence Care home representatives we spoke with gave positive feedback about the practice and their engagement with patients, relatives and carers when discussing and documenting DNACPR forms.	

## 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.	Yes
Staff displayed understanding and a non-judgmental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

Patient feedback	
Source	Feedback
Patients we spoke to	We spoke with patients who gave positive feedback about the caring nature of staff and their helpfulness.
Care home representatives	We spoke with representatives of care homes where the practice looked after patients. They gave positive feedback about the practice and individual staff members on the care given to patients and shown to relatives and carers. This included care at difficult times such as end of life.
NHS Choices	In the past 12 months, 3 comments had been posted with two giving a star rating of five stars and one giving a star rating of four stars. The patients commented on the kind and human approach the staff had given to the patient.
Healthwatch	In the past 12 months, 3 comments had been posted with two giving a star rating of five stars and one giving a star rating of four stars. Patients reported staff were caring.
Comments received by the practice via the electronic access system (June 2022 to September 2022)	Comments left by patients were positive about the care and helpfulness shown by staff.
Feedback the practice received from patients	The practice shared with us some of the feedback they had received from patients. These letters and cards included positive comments about the caring nature of all staff and in cases had named individuals.

## 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)	80.6%	87.2%	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)	78.1%	86.2%	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)	94.9%	95.3%	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)	83.2%	80.4%	72.4%	No statistical variation

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

Any additional evidence
<p>The practice and provider carried out extensive patient feedback using various methods. One significant way was gaining feedback by asking patients to leave comments after every contact.</p> <p>The practice shared with us reports from the computer system (from 2 June 2022 to 22 September 2022) which showed comments in respect of the caring attitude shown by the practice. Included were comments relating to the helpfulness and caring nature of staff.</p>

## Involvement in decisions about care and treatment

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

	Y/N/Partial
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Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Easy to read and pictorial materials were available. We saw this material was routinely used for those patients who needed it.</li> </ul>	

Source	Feedback
Interviews with patients.	Patients we spoke with told us the clinical staff listened to them and discussed their care in ways they understood, and they were included in any decisions made.
Representatives from care homes	Care home representatives we spoke with told us the staff always included the patient, relative and carers as appropriate. They told us they had a positive joint working relationship and a cohesive approach to looking after the patients with the practice staff.

### 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)	85.4%	92.4%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes <sup>1</sup>
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: 1. We saw the practice had made regular and appropriate use of interpreters for patients who did not have English as a first language.	

Carers	Narrative
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Percentage and number of carers identified.	The practice had identified 683 (3.8%) patients as carers. There were 14 young carers registered.
How the practice supported carers (including young carers).	The practice staff both clinical and non-clinical were trained in supporting and identifying carers. When new patients joined the practice, they are asked if they were a carer or if they had a carer. There were posters in the waiting areas and practice leaflets for carers informing them of local support.
How the practice supported recently bereaved patients.	The practice told us that the GPs contacted any bereaved patients and arranged telephone calls or face to face visits as appropriate. The GPs were always involved in any end of life or palliative care of patients.

## 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.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

# 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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	Time
Opening times for both sites:	
Monday to Friday	8.30am to 6pm
Appointments available at various times throughout the day:	

Access to the service

People were 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	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
The practice and provider carried out extensive patient feedback using various methods. One significant way was gaining feedback by asking patients to leave comments after every contact. The practice used an electronic system for patients to access advice and care. This system enabled the patient to send in the question, concern, or request at any time of the day or night. Trained staff reviewed the information sent by the patient regularly during the working day. These staff were part of the duty team (consisting of	



clinical and non-clinical) throughout the day. Patients were directed to the most appropriate clinician or person for the care for example patients requesting an appointment were managed by clinical staff, patients requesting follow up such as form completion were directed to administration teams. After the completion of any contact a request was sent to the patient for feedback and comments. These comments were reviewed by the administration and management team and responded to regularly during the working day. This ensured that any comments that required immediate review or action were action the same day.

The practice shared with us reports from the system (from 2 June 2022 to 22 September 2022) which showed;

- 23,727 requests had been received by the practice and that range of time from receipt to completion was from with 30 minutes to 175 minutes. The practice explained the longer closure time was as a result of the patient being seen in a face to face consultation. No request was closed until the patient had been fully dealt with.
- The data also showed that the details of what the type of appointment the patient had requested including telephone advice or face to face consultation. The data showed that the practice saw more patients were seen in face to face appointments than had been requested by the patients. The practice told us this was because of their clear clinical triage system, GPs and nurses were proactive to see patients face to face when clinically indicated even if the patient had not requested this.
- The practice and patients also told us, those who were unable to use or preferred not to use the electronic system were offered appropriate appointments despite which method they chose to request them.
- The data showed that most patients (over 70%) who responded reported they found the electronic system was better for them in terms of access and response.

Comments included in the report regarding access to the practice included more positive than mixed comments. There were no fully negative comments. Patients commented that they had received a fast response to their request and that they were happy with the service. The mixed comments included that it had been difficult to access the online site but once mastered the system, it was a positive experience.

## 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)	80.7%	N/A	52.7%	Significant Variation (positive)
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)	61.9%	67.5%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or	57.4%	64.8%	55.2%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)				
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)	70.9%	80.3%	71.9%	No statistical variation

Patient feedback	
Source	Feedback
Patients we spoke	We spoke with patients who gave positive feedback about the easy access to and the fast response from the practice.
Care home representatives	We spoke with representatives of care homes where the practice looked after patients. They gave positive feedback about the practice and their regular and proactive response and where necessary immediate response to requests for advice or support.
NHS Choices	In the past 12 months, 3 comments have been posted with two giving a star rating of five stars and one giving a star rating of four stars. Some patients commented they had experienced delays in getting through to the practice on the telephone.
Healthwatch	In the past 12 months, 3 comments have been posted onto the Healthwatch site giving five-star ratings and the patients reported easy access.

## 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.	37
Number of complaints we examined.	Two
Number of complaints we examined that were satisfactorily handled in a timely way.	Two
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	None

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: The provider (SPC) and the practice worked together to ensure all complaints, written or verbal however minor, were reported, investigated and learning was shared. Practice staff we spoke with told us the reporting system was easy to use and they would discuss any negative feedback with their line manager. We saw the practice had logged a complaint even though the patient did not wish to register a complaint as the staff had dealt with their feedback immediately.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint received from relative in relation to care given to her relative.	Practice lead GP and PM reviewed the information. Review recognised that delays were within both the practice and the hospital. The practice made the hospital aware of the areas they needed to address. Practice recognised where a delay for sending information/referral to hospital had occurred. They discussed with the staff and ensured that learning was shared and monitored. The practice had sent an apology and detailed response to the patient. Their letter to the patient included the details of the Ombudsmen should the patient wish to contact them.
Medication paused awaiting test results and was not re started in a timely manner.	The practice undertook a review of the clinical record by the clinical staff member involved and practice manager. Error of protracted re starting of medicine was recognised and immediate action taken, and patient spoken with. The lead GP had a supervision session with the staff member to reflect and identify any learning needs.

## Well-led

## Rating: Outstanding

**We have rated the practice as outstanding for well because;**

The Derby Road Practice is part of Suffolk Primary Care (SPC) which consisted of a partnership of 9 GP surgeries covering a population of 115,000 patients across Suffolk. There were 28 GP partners and around 500 staff who worked across the practices. SPC as a provider demonstrated consistent and cohesive performance across this and all practices to ensure services were safe, effective and well led. For example;

- There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was a deeply embedded system of leadership development and succession planning, which aimed to ensure that the leadership was comprehensive and successful leadership strategies were in place to ensure and sustain delivery within an open culture. Leaders both at provider level and practice level had a deep understanding of issues, challenges and priorities in their service, and beyond. These strategies were stretching, challenging and innovative, while remaining achievable.
- There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. The use of staff resources ensured all practices were staffed safely, this had been particularly effective during and since the COVID-19 pandemic when staff absences were higher.
- Clear governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with the other practices within the group and the provider to improve care outcomes.
- There was a demonstrated commitment to best practice performance and risk management systems and processes. The provider and practice reviewed how they functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.
- The service invested in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant. There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.
- There were consistently high levels of constructive engagement with staff, patient participation groups and people who used the services, including all equality groups.
- There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement was seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. All staff were offered and encouraged to engage with personal development and opportunities within the organisation to use and expanded any skills they had for the benefit of patients and colleagues.

- The provider had been informed they had been short listed for a national award given by the Health and Safety Journal in the patient safety category. The nomination was in relation to the significant work the provider and practice had undertaken in the monitoring and management of medicines, including patient safety alerts and high-risk medicines. Through this centralised management improvement plan conducted in January 2022, The Derby Road Practice improved their monitoring of patients by 56%. As our clinical search found they had further improved on this and the system was fully embedded and has been sustained. This had ensured patients were monitored in the appropriate timeframe and those that did not response/comply were clinically managed. They told us they were very proud of becoming a finalist and planned a celebration with the staff.

## Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The leaders of both the provider organisation (SPC) and the practice demonstrated clear understanding of working as a collaborative organisation whilst maintaining the individuality required to ensure the needs of patients of the practice and this is reflected in the GP patient survey data. Management staff of both the practice and the organisation worked closely with the GP leads to ensure a cohesive and consistent understanding of performance information and effective and clear communication flow was available for the practice staff. Regular and accurate data and information was shared between the provider and the practice to ensure the leadership behaviour was consistent and cohesive. Leaders were knowledgeable in the lead areas but demonstrated they worked across lead areas to ensure safe and effective management.	

## 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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: Staff we spoke with told us they were included in discussions about the strategy of the provider organisation which reflected within the practice ethos. The practice still retained its own strategy to meet their patient's needs. All staff demonstrated they had a common goal to deliver high quality services and care 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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
<p>Staff we spoke with told us they felt able to raise any concerns or ask questions of the practice leaders. They told us the system to report incidents, complaints or concerns was easily accessed and easy to use. They told us the culture within the practice and wider organisation was supportive, educational and strived for the highest standards for both patients and staff. We were told of examples where staff well-being was considered, and support given. Staff and the practice shared with us an example of this where there was a serious accident including fatalities which a staff member attended. The staff member was praised for their contribution at the accident scene by other organisations. The practice and wider organisation ensured the staff member was de briefed, offered well-being support and given time off work to recover from the tragic events. The staff member told us this support from the practice was invaluable and told us they were given an award for their above and beyond actions. Where any behaviour or performance needed review, clear guidelines were used, and support was implemented including mentoring with senior clinical staff or managers.</p>	

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

Source	Feedback
Staff	<ul style="list-style-type: none"> <li>All the staff in the practice work as a team. Roles are clear and we know who to ask for support or advice.</li> <li>The partners and managers are kind, we are treated to some lovely events such as afternoon tea or barbeques to meet socially and for the partners to thank us for our hard work.</li> <li>We enjoy looking after our patients and we continue to look at ways we can help and make things better for patients such as the work with the church and the many refugees in our area.</li> <li>Staff told us they were proud of how they are supported to care for patients as individuals, such as multiple consultations with a patient with learning disability to gain trust for the management of their health.</li> </ul>

	<ul style="list-style-type: none"> <li>Staff told us of improvements they helped to develop for staff well-being for example highlighting and developing policies relating to the menopause for any anyone who needed support or advice.</li> </ul>
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## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Explanation of any answers and additional evidence: The provider and the practice shared with us the plans that were in place and being worked through to recover from the COVID-19 pandemic backlogs such as annual reviews for patients and to continually address new challenges. The practice had clear plans for improving their system for the management of patients with long term conditions to ensure that care was prioritised and delivered to patients in the most effective and timely way. Some of these improvements, although already started, required additional staff to be in place and some required staff to have some further training.	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: We saw a clear connection between the oversight and actions undertaken by the practice and that of the wider SPC organisation. Practice staff told us they found the systems where the centralised office acted, such as managing the recruitment checks and premises management was beneficial and allowed them additional time to concentrate on the practice operations and to support their staff. There was a regular programme of quality checks and audits for the practice to perform. These had been identified by the clear and accurate oversight the centralised management team had of the practice.	

## 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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: The practice and the organisation leads demonstrated that they had clear systems to identify areas of performance issues or learning needs for staff.	

## 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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes <sup>1</sup>
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: 1. The provider (SPC) had undertaken a staff survey in September 2020, this had not been repeated during the COVID-19 pandemic, but a survey had been started prior to our inspection. The survey was still open and therefore the results are not known and have not been analysed. Staff we spoke with were confident that the practice and SPC would discuss and respond to all comments,	

Feedback from Patient Participation Group.

Feedback
We spoke with a member of the PPG who told us they found the practice and practice staff fully engaged in meeting with them. They told us the practice listened to anything they had to say and asked about any complaints or feedback from patients. The practice shared with the PPG any concerns they had identified and actions they had taken in respect of areas such as access. The PPG acknowledged the work the

practice had done to improve patients' experiences and supported the practice in looking at ways they could further patients' understanding of the electronic systems for access.

## 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.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice continuously worked with their staff and the wider organisation to recognise challenges and to meet them to deliver high quality care to their patients. The practice focused on getting patient needs addressed in a timely way and by the most appropriate clinician or staff member. The practice supported staff in further development such as supporting staff with advancements in prescribing qualifications and management of long-term conditions. In addition, non-clinical staff were supported to train and undertake any roles such as advice care coordinator and they could enter the management of the practice structure.</p> <p>The provider had been informed they had been short listed for a national award given by the Health and Safety Journal in the patient safety category. The nomination was in relation to the significant work the provider and practice had undertaken in the monitoring and management of medicines, including patient safety alerts and high-risk medicines. They told us they were very proud of becoming a finalist and planned a celebration with the staff.</p>	

### Examples of continuous learning and improvement

- Continual learning demonstrated by the practice included constant monitoring of the practice electronic system for managing patients requests for advice or appointments. Where patients left feedback or comments the practice responded within one working day.

## 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.