

Care Quality Commission

Inspection Evidence Table

Marine Lake Medical Practice (1-958905318)

Inspection date: 21 and 22 November 2022

Date of data download: 01 November 2022

Overall rating: Requires Improvement

Safe

Rating: Requires Improvement

We rate the practice as requires improvement for providing safe services because the provider did not have adequate systems in place:

- For the appropriate and safe use of medicines. In particular, the processes for monitoring patients' health in relation to the use of medicines including high risk medicines needed to be improved.
- To ensure the oversight of patient safety alerts.

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.	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:	

Safeguarding	Y/N/Partial
<p>There was a designated lead for safeguarding in the practice and staff knew how to report concerns about children and vulnerable adults. Two of the GPs shared the lead role for safeguarding across the organisation and were supported by administrative staff and practice management. Registers for vulnerable adults and children were held and alerts were added to patient records to highlight them. Regular meetings were held at which safeguarding concerns and vulnerable patients were discussed. There was close liaison with other professionals such as social workers and health visitors.</p> <p>GPs and clinical staff were trained to the appropriate level for safeguarding children and adults - level 3. Non-clinical staff and practice managers were trained to level 1. We were told they were considering extending training to Level 2 and 3 for non-clinical staff.</p> <p>Staff recruitment records we sampled showed that Disclosure and Barring Service (DBS) checks had been obtained and assessed.</p> <p>The out of hours service were able to access patients records through the patient record system and use of special notes.</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>We sampled five staff personnel files. These were generally complete and contained the required information. Some evidence such as staff vaccination status was in the process of being obtained and documented.</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:	Y
There was a fire procedure. Date of fire risk assessment:	Y
Actions from fire risk assessment were identified and completed.	2020 Y
<p>Explanation of any answers and additional evidence:</p> <p>Health and safety practises were in place and there was a health and safety risk assessment available and up to date.</p> <p>There was a fire plan and fire safety procedures were in place. Firefighting equipment was in place and regularly checked and serviced. Fire drills had been undertaken and documented. There was an up to date fire risk assessment.</p>	

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.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 10/11/2022	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: The premises and environment were old and, in some areas, in a poor condition, however they appeared clean and tidy. The practice is planning to move into new purpose-built premises next year. Staff had been provided with training in infection prevention and control. An audit of infection prevention and control practices had been carried out. The audit showed areas that required action and an action plan had been implemented. Clinical waste was managed appropriately and within guidance. The domestic cupboard was kept locked, tidy and was suitable for its function.	

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: There were sufficient staff to cover the workload. In the event of absence, staff covered from within the team. Staff reported they felt there were sufficient staff. The practice was actively recruiting clinical and non-clinical staff to compliment the current staffing establishment. Staff were trained in signs of sepsis and medical emergencies. They were able to sign post to urgent and emergency services or get help from clinicians as needed for deteriorating patients. Access to clinicians was good, there were a variety of clinical roles in place, including use of the Additional Roles Reimbursement Scheme (ARRS). ARRS is an NHS initiative to provide funding for additional roles to create bespoke multi-disciplinary teams.	

Information to deliver safe care and treatment

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

	Y/N/Partial
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Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
Paper patient records were stored safely and securely.	
Referrals to specialist services were made in a timely manner overall. Safety netting systems of two week wait referrals for suspected cancers were in place to ensure the appointments were made and taken up by patients.	
Protocols were in place and followed for the management of test results and communication sent from secondary care. At the time of inspection there was little backlog and test results/letters were prioritised and dealt with in a timely manner.	

Appropriate and safe use of medicines

The practice did not have systems in place for the appropriate and safe use of medicines, including medicines optimization

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL 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)	0.84	1.03	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)	11.8%	11.0%	8.5%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
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) <small>(NHSBSA)</small>	6.48	6.21	5.31	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	114.3‰	195.6‰	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) <small>(NHSBSA)</small>	0.64	0.88	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	8.5‰	10.2‰	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.	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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial
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. ²	No
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.	N/A

Medicines management	Y/N/Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>The provider was not able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required. Patients were having blood tests arranged via the hospital, but the provider was not routinely recording that these indicated it was safe to continue prescribing the medicines. This was rectified during the inspection and a system put in place to document test results fully.</p> <p>As part of this inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice. We found:</p> <ul style="list-style-type: none"> Not all patients' health and medicines were reviewed prior to issuing of repeat medicines. For example; <ul style="list-style-type: none"> • 37 patients prescribed Lithium (a medicine used to treat mood disorders), of these, 4 did not have recent blood monitoring results documented on their records and repeat medicine prescriptions were issued without checking their status. We noted they had received monitoring and that blood tests had been done by the hospital team they were cared for, however there was an issue in that the practice had not documented these results in their own records. The practice told us how actions had been taken at the time of inspection, to address this and to call patients in for reviews and blood monitoring. • The processes for monitoring patients' health in relation to the use of medicines, including high risk required improvement. Some medicines are considered high risk because the potential side effects mean appropriate blood monitoring is required. This is for medicines such as Methotrexate, Azathioprine, Lithium, Amiodarone and Warfarin amongst others. Some patients prescribed these medicines had not received appropriate monitoring. <p>For example;</p> <ul style="list-style-type: none"> • 2071 patients were prescribed ACE inhibitor or Angiotensin II receptor blockers (used to treat high blood pressure). Of these 233 had not attended for the required monitoring in the last 18 months. • 70 patients were prescribed warfarin (used to prevent and treat blood clotting disorders and blood clots), out of these 6 had not had their INR monitored correctly (an index used to identify potential clotting problems). We found that patients prescribed other types of anticoagulation 	

therapy – direct acting oral anticoagulants (DOACs), also did not always have the required monitoring.

- Patients prescribed disease modifying anti-rheumatic drug (DMARDs) did not always have the required monitoring. For example, out of 85 patients who were prescribed Methotrexate 10 had not had the required monitoring.
- 28 patients prescribed Amiodarone (an antiarrhythmic medication), 9 had not received full monitoring.
- 127 patients prescribed a potassium sparing diuretic medicine (used to treat heart conditions), 33 had not had the required monitoring.
- We found that the system for coding patients with potential health conditions such as chronic kidney disease and diabetes needed improvement so that patients had access to the health checks they required. Following the inspection, the provider told us how they had started to address this, identified and reviewed patients and had added the appropriate codes as needed.

Following discussion with the clinical team around the findings of our clinical searches, the provider told us and showed us evidence which demonstrated they had immediately assessed those patients at risk, had reviewed their records, and acted to review patients health and monitoring where needed. It was identified that oversight systems on the patient record system were not being used to the full potential in order to ensure appropriate monitoring of patients prescribed high risk medicines. The provider gave us a plan of action at the time of inspection to address the concerns found by the searches which addressed actions needed. They had put systems and processes in place to help ensure patients requiring careful monitoring due to their prescribed medicines were monitored as required. We will follow up these actions at the next inspection of the practice.

- Blank prescriptions were not stored overnight in printers or clinical rooms. On the day of inspection, the process for safe storage of blank prescriptions was revised so that serial numbers of prescription forms were logged to the individual prescribers or consulting rooms. A process was implemented at the time of inspection whereby blank prescriptions were now stored safely and an audit trail in place.
- There were non-medical prescribers employed by the practice, these staff had individual mentors who supervised their prescribing. However, there was no formal documented review of their prescribing. The practice told us they would implement a system whereby individuals prescribing is monitored, reviewed and assessed. They were introducing a new governance system which would help review and monitor prescribers' dashboards.
- Pharmacists were employed by the Primary Care Network and supported the practice. Antimicrobial prescribing was audited regularly, every three months, and findings shared with prescribers to influence improvements. The practice was working to try to improve their prescribing of antibacterial medicines, which was slightly above national average.

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> The practice had appropriate stocks of emergency medicines and equipment that were stored safely and checked regularly. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong through significant event and incident processes and systems. However, they did not have a system for documenting and acting on safety alerts.

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:	12
Number of events that required action:	10
Explanation of any answers and additional evidence: Staff told us they knew how to report significant events. We saw that events had been recorded, investigated and actions had been taken in response and to prevent recurrence. Discussion of significant events was included as a standing agenda item at practice meetings. They were reviewed regularly for themes and trends.	

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

Event	Specific action taken
Blood taken from wrong patient	Learning disseminated was to check carefully the patient prior to taking bloods
Missed diagnosis for skin rash causing delay in treatment	Learning points raised with clinicians and further training given.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	No
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: There was no system in place to ensure oversight and governance of safety alerts. The practice could not demonstrate it was receiving, disseminating and acting upon all alerts and information relevant to general practice. Alerts were assessed for relevance and distributed to staff, staff confirmed they dealt	

with those relevant as they received them, however there was no log in place to monitor these had been actioned. Alerts were not looked at and assessed retrospectively.

We examined five patient records we had identified by searches as needing action following an alert. The provider was unable to demonstrate that all relevant safety alerts had been responded to. We saw that patients remained on combinations of medicines that increased their risk of health problems without anything documented in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered.

This was brought to the attention of the provider and rectified, with review of patients on medicines alerted, patients contacted, and appointments made. An action plan was implemented during the inspection and a system introduced to monitor, assess, action and log safety alerts, including retrospective alerts. The executive team took responsibility for governance of the system and processes.

Effective

Rating: Requires Improvement

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.

We rate the practice as requires improvement for providing effective services because: -

the provider did not have adequate systems in place for the appropriate assessment, monitoring and review of patient's care and treatment.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment were not always 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.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
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
Explanation of any answers and additional evidence:	
Members of the clinical team we spoke with or received feedback from told us they felt well supported in their role and told us how they kept themselves up to date with best practice guidance and shared best practice with the team. Clinicians took responsibility for professional development on an individual basis with support from the provider.	
There were a number of clinical audits undertaken and we saw examples of two cycle audits whereby a second audit had been carried out to check that improvements to patient care had been achieved.	

We ran a number of clinical searches on the patient record system to look at the care and treatment being provided to a sample of patients. Our findings showed:

Patients living with long term conditions were not always managed satisfactorily. For example: -

- Clinical searches conducted identified some patients receiving medicines to treat asthma had not been issued with a steroid treatment card. This was rectified at the time of inspection.
- Some patients prescribed medicines for hypothyroidism were overdue thyroid function tests and review of their medication. This was rectified at the time of inspection.
- Patients who were being treated with disease modifying medicines, commonly used in treating patients with autoimmune conditions, were not being monitored appropriately at the practice. They were monitored by their hospital team, however blood results from hospital were not documented and therefore not available for review by the practice. The provider addressed these issues at the time of inspection and developed an action plan in order to ensure regular monitoring and documentation occurred.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. They had a lead clinician for frailty who worked with the vulnerable patients including those in care homes.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Clinical review of patient records identified some patients with blood tests indicating they may have an undiagnosed long-term condition. This had not been documented in records and therefore they were at risk of not being reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. We found there were three out of five cases we looked at of potential missed diagnosis of diabetes. However, on further investigation, it appeared these were coding errors which could have resulted with the potential of patients not receiving

appropriate monitoring. The provider addressed these issues at the time of inspection and put in place an action plan and process for coding.

- Improvements were needed to ensure patients received timely reviews of their long-term medication. We noted that some patients on four or more repeat medicines needed a medication review. The provider put action in place to identify and review these patients at the time of inspection.
- Patients with long-term conditions were not always offered an effective annual review to check their health and medicines needs were being met. We looked at a sample of patients diagnosed with asthma, chronic kidney disease and hypothyroidism and identified that improvements were needed to ensure they received reviews and follow up as per guidance for these conditions.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice did not always share clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. For example, for patients with long term conditions such as hypothyroidism, the practice did not always obtain and document test results from secondary care which could have impacted on their medicines prescribed and on their health.
- 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.

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)	127	130	97.7%	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)	129	134	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)	128	134	95.5%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	131	134	97.8%	Met 95% WHO based target

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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)	172	178	96.6%	Met 95% WHO based target

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

Any additional evidence or comments

The practice had met and was performing above the 95% WHO target for all childhood immunisations.

Cancer Indicators	Practice	SICBL 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: 30/06/2022) (UK Health and Security Agency)	74.7%	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)	81.4%	60.9%	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)	64.4%	58.3%	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)	55.8%	50.1%	55.4%	No statistical variation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Any additional evidence or comments

The practice acknowledged it was below the 80% target for cervical cancer screening. Initiatives were in place to help increase uptake, for example, promotion campaigns and record alerts for opportunistic screening to occur. This had resulted in an increase and unverified data given to us by the practice indicated they were now working towards achieving the target.

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 provider had a programme of audit. We saw examples of two cycle audits and improvements linked to prescribing practices and other audits undertaken.

Audits included:

- Infection prevention and control
- Minor surgery
- Hormonal monitoring in transgender
- Dermatology referrals
- Significant event analysis
- Cancer referrals
- Opiate prescribing
- Topiramate prescribing
- Total triage system

Any additional evidence or comments

Audit of the clinically led total triage system had demonstrated improvements in appropriate triaging and access to clinicians and appointments.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
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 saw evidence of induction checklists completed for the most recently employed staff that was relevant to their role. We also saw annual appraisals had been completed for all staff.</p> <p>Staff we spoke with and feedback in staff questionnaires indicated that staff felt well supported in their role and appropriately trained.</p> <p>Staff had their skill and competencies checked on employment and monitored. Non-medical prescribers were supervised and mentored by medical clinicians, including monitoring of their prescribing. However, we saw that formal documented consultation audits and prescribing audits had not been carried out with non-medical prescribers. The provider told us of their plan to implement a formal monitoring system of non-medical prescribers.</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
<p>Explanation of any answers and additional evidence:</p> <p>There was evidence of multi-disciplinary meetings held regularly, for example, safeguarding.</p> <p>Patient records were summarised for new patients. The practice used special notes within the patient record system to share important information about patient's needs. Patient records were accessible to external providers such as the extended hours and out of hours service.</p>	

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 supported to manage their health and prevent avoidable disease. The practice was proactive and opportunistic in providing health promotion and health prevention care, advice and treatments. They had implemented a patient health kiosk in reception for patients to check their blood pressure and weight, this fed into the patient health record.</p> <p>There was a clinical lead for frailty and care homes, vulnerable patients were identified and highlighted. We saw that end of life care was coordinated and delivered by the practice with involvement from other health and social care professionals. Regular multi-disciplinary team meetings for those on end of life care had not taken place during the pandemic, however, we were told these would soon be reinstated.</p>	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
<p>Explanation of any answers and additional evidence</p> <p>Our clinical review of notes where a DNACPR decision was in place identified patients' views had been sought and respected. We saw that information had been shared with relevant agencies.</p>	

Responsive

Rating: Good

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review all of the rating for responsive at this time. Therefore, we only assessed access under responsive. Responsive remains rated as Good.

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am-6.30pm
Tuesday	8.30am-6.30pm
Wednesday	8.30am-6.30pm
Thursday	8.30am-6.30pm
Friday	8.30am-6.30pm
	8.30am-6.30pm
Extended hours appointments available:	
Monday	6.30pm-8.30pm
Tuesday	6.30pm-8.30pm
Wednesday	6.30pm-8.30pm
Thursday	6.30pm-8.30pm
Friday	6.30pm-8.30pm Provided by the PCN
Saturday	9am-5pm Provided by the PCN

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
Explanation of any answers and additional evidence:	

There were a number of ways patients could book appointments. For example, in person, by telephone, online, eConsult or via an App. Appointments offered included telephone consultations, eConsult, video consultations, face to face and home visits. Pre bookable appointments were available.

The practice had introduced a clinically led total triage access system. Care navigators were trained to process appointment requests with a standardized process for managing access of all types. Patients' needs were prioritised. Patients requesting a same day/urgent appointment were asked to give further detail so that appropriate consultation/appointment could be offered, even when all appointments were taken that day. Children and vulnerable people were prioritised and clinicians consulted when requesting appointments.

Support was in place for making appointments/contacting the practice for vulnerable people and those who face communication barriers, including those digitally excluded. Alerts on a person's record highlighted those who were vulnerable or had an impairment. Interpreters were available for patients whose first language is not English.

The telephone system was limited by the nature of the premises; however, it had been reviewed in order to provide better access by telephone. The practice was moving to new premises next year in which there would be better IT facilities including the telephone system.

There were arrangements in place for signposting to other providers and organisations for primary care services such as phlebotomy, podiatry, minor injuries, pharmaceutical, and other local health and wellbeing services.

We discussed the appointment system, appointment availability and waiting times. Waiting times were minimal and distributed according to need. Protected daily appointment slots were available for urgent needs. Usually appointments were available daily with a clinical member of staff. The practice showed us unverified data that demonstrated they were below average for ED attendance, emergency admissions and patients presenting to ED with low acuity problems.

Out of Hours (OOHs) services were available by calling NHS111.

Extended access was provided through the practice and the Primary Care Network (PCN) Monday – Friday evenings (6.30pm-8pm and Saturdays).

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL 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	35.9%	N/A	52.7%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
their GP practice on the phone (01/01/2022 to 30/04/2022)				
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)	48.0%	58.3%	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)	48.5%	59.7%	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)	72.8%	74.5%	71.9%	No statistical variation

Any additional evidence or comments

The practice was able to access call queue monitoring software. This allows staff to be redeployed to keep the average queue waiting times to 15 minutes.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	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: The leadership and organisation structure were clearly defined and identifiable. Staff told us leaders were visible and approachable. Staff felt well supported. Leaders took responsibility and accountability for challenges and concerns identified. They responded immediately to our concerns and acted to implement improvements where needed. There was evidence of succession planning in place.	

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: There was a mission statement displayed around the practice. Staff knew and could articulate the ethos and vision of the provider. Staff shared the vision and values to provide high-quality person-centred care. Business planning was evident. Plans for service development and improvements were discussed at meetings and staff were involved. Plans were progressing for the practice to move into new purpose-built premises next year. This would provide optimal premises for a healthcare environment and support staff to deliver high quality care in suitable surroundings and with advanced technology.	

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.	Y
Explanation of any answers and additional evidence:	
Discussions with staff and feedback we received in CQC feedback forms indicated that staff felt well supported in their roles. They felt that the culture of the practice was one of openness and honesty. Staff told us they felt they would be supported if they raised concerns.	

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

Source	Feedback
Staff interviews	'I love my work, we (staff) are all supportive of each other and work together as a team'.
Staff feedback forms	'Staff are very friendly to patients and each other, good processes, and structure in place to make sure patients are monitored and targets are met'

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
Explanation of any answers and additional evidence:	
The provider had systems and structures in place to demonstrate effective and sustainable governance of the service. Quality improvement processes were embedded and demonstrated improvements to	

service and care and treatment of patients. These included analysing and acting upon significant events and complaints, audit, quality improvement activities and patient and staff involvement.

There were policies and procedures in place which were kept up to date and reviewed to support practice.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
Leaders and managers responded and acted swiftly during the inspection to manage and mitigate risks to patients where their health and medicines had not been monitored as required. Some of the issues identified were rectified by updating the patient risk oversight systems in place. Assurance was provided that these systems would be regularly reviewed and updated.	
The practice had a range of risk assessments in place that were reviewed and acted upon.	
An audit programme was in place with demonstrable improvements seen as a result of audits.	
The new build premises architecture considered sustainability in its plans and building.	

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

Explanation of any answers and additional evidence:

All staff worked together and were responsible for monitoring performance and data linked to patient outcomes, for example, Quality and Outcomes Framework (QOF).

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:	
Leaflets, posters and the practice website contained information regarding patient records and online services.	

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.	Partial
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 Patient Participation Group (PPG) has disbanded during the pandemic. The practice was actively recruiting and developing a new PPG. We spoke to some patients who had been approached by the practice and were keen to get involved. We saw evidence of terms of references for the group and plans to start meetings in January 2023.

Although a formal staff survey was not conducted staff felt able to contribute views and make suggestions at meetings, appraisals and by the open behaviour of the leaders and manager.

The practice reviewed results of the National GP Patient Survey (August 2022) and acted upon them. For example – investigating how improvements to the phone system could be made within the limitations of the current premises and technology infrastructure.

The provider was working with the local primary care network (PCN) to support services within the community, for example, the practice had good access to the PCN pharmacist.

Continuous improvement and innovation

There were 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:	
The practice supported and encouraged learning, training and development with protected learning time. There was evidence of learning and improvements through significant event and complaints analysis and through audits.	

Examples of continuous learning and improvement

The provider was aware of challenges to the service and across the health and social care landscape. They used technological advances for reaching out to patients in order to improve health outcomes. Although they used digital technology widely, they recognised and identified a proportion of their patients who may be digitally excluded and therefore vulnerable and acted to include them.

An example of innovative practice can be seen in the introduction of the total triage model for access. The practice established the acute triage services 18 months ago and have integrated and optimized chronic disease management into this. The triage model proved successful and they now have practices across the UK visiting them and implementing their model for patient access. Staff were upskilled in care navigation and they now have a dedicated triage and access team.

The practice leads and participates in various research projects. They have been recognised for their contribution in research (both NHS and commercial). More recently for their contribution to the national

projects for COVID19 interventions, Stop RSV (respiratory syncytial virus) and will be commencing piloting BRIT2 (an integrated electronic dashboard detailing individual prescribing habits).

The practice has integrated ARRS (additional roles reimbursement scheme) / PCN staff into their workforce.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a SICBL 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 SICBL 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.