

Care Quality Commission

Inspection Evidence Table

Central Surgery (1-591580149)

Inspection date: 6 December 2022

Date of data download: 07 November 2022

Overall rating: Inadequate

The practice is rated as inadequate as they did not always ensure that care and treatment was provided in a safe way to patients. Effective systems and processes to ensure good governance in accordance with the fundamental standards of care were ineffective in a number of areas.

Safe

Rating: Inadequate

We rated the practice as inadequate for providing safe services because:

- Staff were not trained to the appropriate level for safeguarding children and vulnerable adults.
- Disclosure and Barring Service (DBS) checks had not been undertaken for all staff and risk assessments to mitigate risks were not carried out.
- Recruitment checks had not been carried out appropriately.
- Staff vaccinations and records of vaccinations had not been maintained in line with current guidance.
- Actions had not been taken in response to the health and safety and fire safety risk assessments.
- Appropriate standards of cleanliness and hygiene were not always met. Staff had not all received training on infection prevention and control.
- Staff were not suitably trained in emergency procedures.
- Individual care records did not contain all patient information. For example, blood test results were not routinely added to patient notes. Medicine reviews did not always contain documentation of discussions that had taken place with the patient.
- There was a backlog of summarising of new patient notes.
- Blank prescriptions were not logged or tracked at the branch site.
- There was no embedded process in place to review the prescribing practice of non-medical prescribers.
- There were some gaps in the process for monitoring patients' health in relation to the use of medicines including high risk medicines.
- The practice did not hold all of the recommended emergency medicines at either the main or the branch site. There was no documented risk assessment in place to demonstrate whether the risks of not holding these medicines had been assessed and mitigated.
- Learning from significant events was not widely shared with practice staff.
- Actions had not always been taken for safety alerts received.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, training and recruitment checks were not sufficient.

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.	N
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.	N
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
<p>Explanation of any answers and additional evidence:</p> <p>Staff were not trained to the appropriate level for their role as outlined in the Intercollegiate Guidance for Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff published in January 2019. The practice training records for November 2022 showed non-clinical staff had been trained to level 1 for safeguarding adults and children. The training record showed not all staff had completed safeguarding training. For example,</p> <ul style="list-style-type: none"> • Training records for administrative and reception staff, showed 7 out of 27 staff had completed safeguarding adults level 1; and 3 had completed safeguarding children level 1. • Training records for GPs, showed 9 out of 20 had completed safeguarding adults level 3; and 14 out of 20 had completed safeguarding children level 3. <p>There was no record of other safeguarding training, for example, face to face that may have been completed by clinical staff. Following the inspection, the provider informed us that all clinical staff had attended face to face safeguarding level 3 training in January 2023.</p> <p>DBS checks had not been undertaken for all staff. The practice was in the process of reviewing the DBS checks for all staff. However, there were no records kept of who had a DBS check. We noted that there was one GP and two practice nurses without a current DBS check. There were no risk assessments in place to determine if it was safe for them to carry out their job roles without a DBS check.</p> <p>One of the GPs was the identified lead for safeguarding, and they were supported by two administrative staff members. We found good systems in place to manage safeguarding processes, in particular, clear recording of discussions during multi-disciplinary meetings which were reflected in clinical records. Staff were aware of who to go to for safeguarding advice.</p>	

Recruitment systems	Y/N/Partial
---------------------	-------------

Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed three staff files and found gaps in the records kept. For example,</p> <ul style="list-style-type: none"> Staff members within the administrative team on a fixed term contract; records did not include an application form or curriculum vitae, detailing their full employment history and no evidence of conduct, such as references, in previous employment. We saw GP recruitment records with no evidence of conduct, such as references, in previous employment. <p>The practice did not have a record to show staff had received vaccinations appropriate for their role. They had recorded when staff had received a hepatitis B vaccination. However, there was no record kept of other recommended vaccinations or the staff members' immunity status.</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: June 2022	Partial
There was a fire procedure.	Y
Date of fire risk assessment: June 2022 Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:</p> <p>A health and safety risk assessment had been carried out for the main site. There was no health and safety risk assessment for the branch site. The risk assessment outlined that there had been minimal changes regarding the issues identified at the previous risk assessment.</p> <p>At the branch site there was a water leak in the reception area close to electrical cables which was picked up by the previous risk assessment as needing to be addressed. There was a screen at the reception desk that was not secured and could be easily removed by a member of the public. Staff had raised this as a concern; however, there was no evidence that concerns had been explored or followed up. Following the inspection, the practice provided a health and safety risk assessment that had been completed in June 2022 for the branch site. There were actions identified that needed completing. For example, gas appliances had not been inspected, there was no carbon monoxide detector fitted with a fuel burning appliance and a legionella risk assessment had not been completed. We noted the gas boiler had been serviced in the previous 12 months. There was no action plan in place to address the identified actions.</p> <p>The health and safety risk assessments for both sites indicated that compliance was low for health and safety.</p> <p>Fire safety was taken into consideration as part of the health and safety risk assessment. We reviewed the fire safety logbook and found,</p> <ul style="list-style-type: none"> Weekly fire alarm tests were not carried out consistently. There had been a recorded check in October 2022 and another in December 2022. Monthly fire extinguisher checks had not been recorded. The last recorded date of a check was May 2022. 	

- Fire drills were not carried out at either site. The last recorded fire drill was November 2020.
- The weekly fire door checks had not been completed.
- An external company had completed a fire detection and alarm system check and an inspection of the emergency lighting system in October 2022.

The fire alarm at the branch site was a manual alarm not connected to any fire safety systems.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: November 2022	Partial
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The training records showed that 8 out of 58 staff members had completed infection prevention and control (IPC) training. The practice had identified that IPC training was not required for administrative and reception staff. One of the GPs was identified as the lead for IPC within the practice. However, they had not received additional training for this role.</p> <p>The practice had used an independent IPC Audit Practitioner to carry out an IPC audit. The audit covered IPC measures at the main site. There was no IPC audit of the branch site. Following the inspection, the practice provided an IPC audit dated September 2022 for the branch site.</p> <p>There were issues identified in the IPC audit that the practice had not put an action plan in place for as they were waiting to hear if they would be receiving support for a refurbishment. The issues included elbow taps and mixer taps to thermostatically control hot water in the clinical areas.</p> <p>We found the main site to be visibly clean and tidy.</p> <p>At the branch site we found some IPC concerns. For example,</p> <ul style="list-style-type: none"> • There was carpet flooring in one of the consultation rooms. There was no documented evidence that the carpet had been deep cleaned or any arrangements in place for deep cleaning. • There was a privacy curtain in one of the consultation rooms. There was no record of when this had been replaced or cleaned. • There were no spillage kits located. Spillage kits are used to safely clean bodily fluids. • In the cleaners' room there was a visibly dirty sink with heavy limescale, and the mops were not stored with the heads upright to air dry. The mops were damp and left head down in the buckets used for cleaning. • There were no cleaning logs kept at the branch site. We were informed that the cleaners had not attended the branch site for one week but had attended on the day of the inspection. 	

Risks to patients

There were gaps in 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.	Partial

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.	N
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
<p>Explanation of any answers and additional evidence:</p> <p>The branch site was not always fully staffed. On the day of the inspection there was one receptionist who was responsible for manning the reception desk, responding to patient requests and answering incoming internal telephone calls.</p> <p>It was not evident that staff were suitably trained in emergency procedures. For example, there was no record that staff had completed basic life support training and only 19 out of 58 staff members had completed fire safety training.</p> <p>Reception staff had not completed sepsis training. However, they were supplied with written prompts to help them identify red flag symptoms when speaking with patients.</p>	

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	N
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.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We carried out a remote review of the patient clinical record system and found the documentation was not always adequate. For example, blood test results were not added to patient records when viewed on the secondary care system.</p> <p>The practice had a backlog of summarising of new patient notes. There was one administrative staff member who had received some training to complete the summarising. However, it was not clear that this training related to summarising in primary care. There was no allocated time for summarising, we were informed it was done on an ad hoc basis when a GP requested notes for a new patient. The practice did not have an action plan in place to clear the backlog and was not able to provide clarity on the extent of the backlog. Following the inspection, we were informed that the practice intended to outsource the</p>	

summarising to an external company to clear the backlog and train staff within the practice to complete the task in the future.

We reviewed the practice inbox for receiving test results and communications from other providers and found 2018 items that had not been viewed or processed. During the inspection, the practice reviewed the inbox and cleared the backlog of items; explaining that once items had been actioned, they were not being cleared off the clinical system.

Appropriate and safe use of medicines

The practice did not have adequate systems for the appropriate and safe use of medicines, including medicines optimisation

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)	0.71	0.85	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)	8.8%	9.4%	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)	4.21	5.16	5.31	Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	131.6‰	121.6‰	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) (NHSBSA)	1.07	0.71	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	7.7‰	8.3‰	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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England 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
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.	N
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>Blank prescriptions were held securely and tracked at the main site. There was not a log held at the branch site to log and track blank prescriptions.</p> <p>There was no embedded process in place to review the prescribing practice of non-medical prescribers. We were informed there had been some reviews of prescribing in the month prior to the inspection. Staff informed us they could consult with the duty GP if they had a query when prescribing.</p>	

Medicines management	Y/N/Partial
<p>We reviewed the patient record system and found the medicine reviews completed by a clinical pharmacist were comprehensive with appropriate documentation. There were other medicine reviews that had a code marked to indicate a medicine review had taken place. However, there was no documentation of the discussion that had taken place with the patient or to show that medicines were prescribed appropriately.</p> <p>Our review of the patient record system showed there were some gaps in the process for monitoring patients' health in relation to the use of medicines including high risk medicines. For example,</p> <ul style="list-style-type: none"> • There were 50 patients prescribed a medicine used to treat autoimmune conditions. Our search showed 33 of these may not have had the required monitoring. We reviewed 5 patients and found blood tests completed in secondary care were not documented in the patients records. There were 2 patients who did not have a documented shared care agreement with the secondary care provider. The day of the week the medicine should be taken was not recorded. A safety alert issued in September 2020 prompted clinicians to record the day of the week the medicine should be taken to avoid an inadvertent overdose. • There were 79 patients prescribed a potassium sparing diuretic. Our search showed 23 of these may not have had the required monitoring. We reviewed 5 patients and found in the two weeks prior to the inspection, the practice had recognised monitoring was due and invited patients for a blood test. <p>The practice did not hold all of the recommended emergency medicines at either the main or the branch site. For example, they did not have</p> <ul style="list-style-type: none"> • medicines to treat nausea and vomiting • steroids for the treatment of croup in children • pain relief injections • medicines to treat seizures. <p>There was no documented risk assessment in place to demonstrate whether the risks of not holding these medicines had been assessed and mitigated. Following the inspection, the practice provided a risk assessment for the emergency medicines. This did not contain any detail for the main site and insufficient detail for the branch to outline control measures in place for those emergency medicines not held.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, learning was not shared with all appropriate practice staff.

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.	N
Number of events recorded in last 12 months:	12

Number of events that required action:	12
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a process in place for reporting significant events. An electronic reporting form was available on the practice computer system for all staff to access. A log of all significant events was kept to help identify trends.</p> <p>We reviewed a sample of the 5. We noted the learning was recorded in the minutes of the clinical governance meetings.</p> <p>The clinical governance meetings were held once a month and were attended by the GP partners and practice manager. The salaried GPs were invited to the meetings; however, they were held on a day of the week when these GPs were not working. The practice had recognised this and planned to change to a different day of the week in the future.</p> <p>The nursing team were not on the email distribution list to be invited to the meetings or receive the minutes of the meetings where the learning from significant events was shared.</p>	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Results from an investigation were telephoned to the practice. A task for action required was sent to a GP who was not working at the time.	The error was identified, and appropriate action was taken in response to the result of the investigation. Staff were reminded that when results are received by telephone they should be sent to the duty GP for action.
A patient was directed to the community pharmacist when they had symptoms that required them to be seen by a GP.	An advanced nurse practitioner contacted the patient and advised them to attend A&E. Staff were reminded of the process to follow when referring patients to a community pharmacist and the symptoms that would indicate a patient should be seen by a GP. They were advised to consult with the duty GP if they were in doubt.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Safety alerts were received in the practice by the practice manager who shared with clinicians and appropriate staff if actions were required.</p> <p>We reviewed the clinical record system and found that actions had not always been taken for the alerts received. For example, we found 305 patients were prescribed a specific medicine to treat diabetes that had a rare but serious side effect. A safety alert issued in 2019, advised clinicians to ensure patients sought urgent medical attention if they experienced symptoms. A sample of 5 of the 305 records were reviewed showed patients had been notified of the side effect in the week prior to the inspection. It was not documented in the patients' record that side effects had been discussed when the treatment started or when they had received a medicine or diabetes review.</p>	

Effective

Rating: Requires Improvement

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

- Patient records did not contain sufficient documentation to reflect their review or consultation. This included patients with long-term conditions.
- The uptake for cervical screening was below the 80% target set by the UK Health and Security Agency.
- There was minimal quality improvement activity carried out.
- Induction of new staff and training was not clearly documented or evident.
- Appraisals had not been completed for all staff.
- Records of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were not fully documented in the patients' records.

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 generally assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. However, documentation of this was not always evident.

	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.	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: We reviewed the patient record system for patients that had received more than 10 prescriptions for medicines that are used for the short-term relief of anxiety and insomnia. There were 160 patients	

identified and we reviewed 5 of these and found that there was no evidence that patients had been informed of the risk of addiction. We saw that attempts to wean off these medicines had been made for 3 of the patients.

Medicine reviews completed did not contain all the details about the review and did not document if treatment options remained effective or whether the medicines taken remained appropriate.

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.
- 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.
- 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.

Management of people with long term conditions

Findings

A remote review of the clinical record system showed that patients generally had received long-term condition reviews to check whether their health and medicines needs were being met. However,

- There were 65 patients diagnosed with asthma who had been prescribed 2 or more courses of rescue steroids in the previous 12 months. We reviewed 5 of these patients and found that while the initial assessment for these patients was good, the guidelines were not followed to review these patients after 48 hours and they were not issued with a steroid card.
- There were 51 patients diagnosed with chronic kidney disease. Of these 9 showed as they may not have had appropriate blood monitoring in the previous 9 months. We reviewed 5 of these patients and found they were treated and monitored in secondary care. The practice had not added the blood test results to the patient records.
- There were 643 patients diagnosed with hypothyroidism. Of these 42 showed as they may not have had appropriate blood monitoring in the previous 18 months. We reviewed 5 of these patients and found 3 had not had blood monitoring and 2 had been monitored in secondary care. The practice had not added the blood test results to the patient records.
- There were 73 patients with complications of diabetes who had a high blood sugar level. We reviewed 5 of these patients and found medicine reviews had been recorded but they did not all show documentation to indicate that monitoring was up to date. There was a lack of documentation to confirm medicines patients were taking were still appropriate and had the desired effect without causing any side effects or complications.

The review of the clinical record system showed patients with a potential diagnosis of diabetes were correctly reviewed and identified as pre-diabetic in the patient notes.

Patients with long-term conditions were offered an annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

Staff who were responsible for reviews of patients with long-term conditions had received specific training. We were informed the nursing staff trained to review patients with asthma had left the practice and these patients were often directed to the extended access service that held evening and weekend appointments for a review.

Adults with newly diagnosed cardio-vascular disease were offered statins.

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)	186	194	95.9%	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)	201	215	93.5%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	201	215	93.5%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	202	215	94.0%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)	271	291	93.1%	Met 90% minimum

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
--	--	--	--	--

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 contacted the parents of guardians of children not brought for their immunisation appointments by telephone and sent reminders of appointments.

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)	68.3%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	52.1%	55.3%	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)	58.6%	60.0%	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)	57.9%	57.0%	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 were aware they were below the 80% target set by the UK Health and Security Agency for the uptake of cervical screening.
There had been some staff leave the nursing team and one new practice nurse had just been trained to undertake cervical screening which had affected the availability of appointments. We were informed the practice planned to recruit additional nurses.
Appointments for cervical screening were available in the evenings and weekends with the enhanced access service.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment. There was some review of 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.	N
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Any additional evidence or comments

The practice did not have a programme of quality improvement activities. They informed us they carried out searches of the clinical system to identify when patient care required actions.

There were 3 single cycle audits undertaken by the practice. For example,

- A family planning audit looked at the insertion and removal of long acting reversal contraception. The audit involved data collection to check if appropriate records were maintained, patient education was given, and any complications were identified. Actions were identified, such as, better documentation and sexually transmitted infection screening. A reaudit was planned.
- A minor surgery audit looked at diagnosis accuracy and post-operative wound complications. Actions were identified to refer patients to GPs with a special interest in dermatology and to avoid delays in carrying out minor surgery. A reaudit was planned.
- An audit of prescribing of a medicine used to prevent blood clots was carried out by a GP registrar. The audit looked at whether patients had received the required monitoring for this medicine. They found out of 50 patients 1 required blood tests and were invited to the practice for these. A reaudit was planned for 6 months' time.

Effective staffing

The practice was unable to fully 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.	Partial
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.	Partial
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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: There were gaps in the training records held by the practice to demonstrate that staff had completed mandatory training. Additional training for staff to carry out their roles effectively was provided. For example, for those completing long-term condition reviews.	

We were informed by the practice that staff had completed task and skills matrixes to identify areas of additional training and learning required.

The providers Induction Statutory and Mandatory Training Policy did not contain details of the induction process for new staff. We were informed by some staff that new staff were trained on the job by others that were new to the role.

The practice manager had completed one to ones with all staff members and had a plan in place to complete appraisals. Not all staff had received an appraisal in the previous 12 months.

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
Explanation of any answers and additional evidence: The practice had regular meetings, every month, with community staff to discuss patients with complex needs or those who were receiving palliative care.	

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
Explanation of any answers and additional evidence: The practice had access to a social prescriber who provided support for patients when needed.	

Consent to care and treatment

The practice was unable to demonstrate that it 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.	Partial
<p>Explanation of any answers and additional evidence</p> <p>Decisions regarding DNACPR were recorded in the patients' records. However, the forms used to document patients' views and discussions held were not stored in the patient records. We were informed that these were kept with the patient.</p>	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Patient feedback	
Source	Feedback
NHS Website	There were 4 reviews left on the NHS Website in the 12 months prior to the inspection. There was 1 review that was positive regarding staff and their professionalism and care provided. There were 3 reviews that were negative regarding telephone access and obtaining requested prescriptions.

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 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)	75.2%	86.1%	84.7%	Tending towards variation (negative)
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)	74.5%	84.3%	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)	88.3%	93.7%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to	58.4%	74.9%	72.4%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
the overall experience of their GP practice (01/01/2022 to 30/04/2022)				

Any additional evidence or comments

The practice informed us they had not taken any actions in response to the National GP Patient survey.

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

Any additional evidence

The practice had started to use the NHS Friends and Family Test (FFT) to gather feedback from patients. They had been collecting feedback for 4 weeks, however, they had not analysed the results at the time of the inspection. The FFT was created to help providers understand whether patients were happy with the service provided or where improvements were needed.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: The practice displayed information about local services and support available to patients. Easy read materials were available. The practice had information regarding advocacy services for patients to access.	

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 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)	84.9%	90.5%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: Alerts were used on the patient record system to identify patients who required extra support. For example, for patients that were hard of hearing or for those who required interpretation services.	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 1025 patients who were carers which equated to 5% of the practice population.
How the practice supported carers (including young carers).	The practice did not have an identified carers lead. There was support information available for carers on the practice website. Carers were offered an annual flu vaccination.
How the practice supported recently bereaved patients.	A condolence card that contained information regarding support services was sent to patients who were recently bereaved. An appointment with a GP was offered to these 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.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: There was an electronic check in for patients to use to avoid queues at the reception desk. Incoming telephone calls were not answered at the reception desk.	

Responsive

Rating: Requires Improvement

We rated the practice as requires improvement for providing responsive services because:

- There were concerns with access to the branch site. The opening hours were not clearly publicised and the site was not always adequately staffed for the clinics being run.
- Facilities at the branch site were limited for patients using a wheelchair.
- The National GP Patient Survey scores published in July 2022 and feedback showed patients were not satisfied how easy it was to get through to someone at their GP practice on the telephone.
- Learning from complaints was not widely shared with all staff.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. However, there was difficulty for some patients to access them.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Services were delivered at a main and a branch site.</p> <p>The main site was appropriate for the services delivered. There was a ramp to the rear of the building that was suitable for wheelchairs and pushchairs. There was a consultation room available on the ground floor and access enabled toilets.</p> <p>The branch site had level access; however, it did not have automatic doors at the entrance to assist patients in wheelchairs. The two toilets in the waiting area were not access enabled or suitable for wheelchairs. In particular, they were not fitted with grab rails or emergency pull cords. There was one toilet near to the clinical rooms that had grab rails. We were informed by the practice that patients with physical disabilities were encouraged to use the main site.</p> <p>There was limited storage at the branch site, and we found cardboard storage boxes located in the back-office area behind the reception. There was a water leak in the reception area which was close to electrical cables. We found that this risk was identified during previous health & safety risk assessments; however, there was no evidence that actions had been taken to address this risk.</p>	

Practice Opening Times

Day	Time
-----	------

Opening times Central Surgery:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Opening times Bilton Green Surgery:	
Monday	8.30am to 5.30pm
Tuesday	8.30am to 5.30pm
Wednesday	8.30am to 5.30pm
Thursday	8.30am to 5.30pm
Friday	8.30am to 5.30pm
The opening hours for Bilton Green Surgery advertised on the practice website did not reflect the actual opening hours. The practice website states the branch is open on Tuesdays only. However, we were informed by the practice it was open every day.	
The branch site was not always fully staffed. For example, on the day of the inspection, the practice nurse clinic for administering childhood immunisations was moved to the main site as there was not a GP available to work alongside the practice nurse and to be available in the event of emergencies. We observed that 10 out of the 16 scheduled appointments were rebooked at the main site.	
Appointments were available throughout these times.	
Appointments could be booked either by telephone or online.	
Telephone and face to face appointments were available.	
The practice used a pharmacy referral service for patients with minor illness symptoms who could not access an appointment. A message was sent to the pharmacy via the patient record system and the patients received a call back the same day for an assessment of their symptoms and advice on over the counter treatments and self-care.	

Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Appointments were available outside of school hours.
- Pre-bookable appointments were available to all patients at additional locations within the area, as the practice was a member of a Primary Care Network (PCN). Appointments were available in the evenings from 6.30pm to 8pm and weekends.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

- The practice was the lead within the PCN for patients from Ukraine. They received patients from a local hotel that housed refugees and asylum seekers. A register was kept of these patients and they were all offered routine vaccinations within 14 days of registration.

Access to the service

People were not always 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	Partial
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

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 their GP practice on the phone (01/01/2022 to 30/04/2022)	22.0%	N/A	52.7%	Significant Variation (negative)
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)	44.3%	59.4%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	46.0%	56.3%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the	66.1%	72.7%	71.9%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)				

Any additional evidence or comments
<p>The practice was aware of the National GP Patient survey scores particularly in relation to how easy it was to access the practice via the telephone.</p> <p>Additional reception staff had been recruited and administration staff were used at peak times to answer the telephone. One of the administration team managers assessed the impact of these measures and adapted the staff rotas accordingly.</p> <p>There was a facility on the practice website to ask a GP a non-urgent query.</p>

Source	Feedback
Share your experience forms	Prior to the inspection, patients were encouraged to complete 'Share your experience' forms through the CQC website. We received comments from 2 patients that were negative regarding telephone access and appointment booking.
The NHS Website	There were three negative comments left in the previous 12 months regarding getting through to the practice via the telephone. One person stated they had waited an hour, and another said they had tried to telephone several times.

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.	34
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There had been a delay in responding to some complaints received by the practice prior to the current practice manager starting work in May 2022. We noted that these were responded to appropriately with an apology for the length of time taken to respond. We found an improvement in complaints management from May 2022.</p> <p>Learning from complaints was discussed at the clinical governance meetings. However, all staff were not invited to these meetings and the learning was not widely shared with all staff.</p>	

Examples of learning from complaints.

Complaint	Specific action taken
The length of time taken to receive a telephone consultation.	An apology was issued, and a discussion was held with the GP at the time of the appointment. An improvement was made to the initial questions asked by reception staff when an appointment was requested. More face to face appointments were made available.
A request for patient records had taken too long and were not received when expected.	The records were sent with an apology for the length of time taken. The tasks and workflows of the administration team were reviewed and streamlined.

Well-led

Rating: Inadequate

We rated the practice as inadequate for providing well-led services because:

- There was a lack of managerial oversight for many processes including recruitment, medicines management and risk assessments. There was no action plan in place to clear the backlog of summarising.
- There was no succession planning in place. There were 3 out of the 7 GP partners who had not registered with CQC.
- The ratings from previous CQC inspections were not displayed.
- Staff feedback was generally negative. They did not always feel able to raise concerns or feel supported.
- There was a lack of clinical oversight for staff working in the practice, in particular, non-medical prescribers.
- Quality improvement was limited to single cycle audits.
- Learning from significant events and complaints was not widely shared.

Leadership capacity and capability

Leaders could not 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.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	N
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: The practice had a change to the management in the previous 12 months and there had been amendments made to the working practices. Records viewed showed a number of historical gaps under the previous managerial structure. However, under the new managerial structure we found there remained a lack of managerial oversight to many processes and staff reported dissatisfaction with the changes made and how they were implemented. Staff reported that the leaders were not always approachable and records we viewed, such as meeting minutes did not demonstrate how staff were being included in the change process. There was no succession planning in place. We were informed that a GP partner was due to retire next year with other GPs nearing retirement age. There had been no discussions regarding the future of the partnership. There were 7 partners in the practice. However, only 4 of these were registered with CQC as part of the partnership. The ratings from previous CQC inspections were not displayed in either the main practice or the branch site. There was no information on the practice website regarding CQC ratings. Following the inspection, the CQC ratings are now displayed on the practice website.	

Vision and strategy

The practice had a clear vision, but it was not supported by a 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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice had a documented mission statement that was available on their website. Staff reported they did not always feel included in changes made in the practice.	

Culture

The practice culture did not effectively support 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.	N
There was a strong emphasis on the safety and well-being of staff.	Partial
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.	Partial
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: Staff reported that they did not always feel able to raise concerns. For example, some staff reported when they had raised concerns regarding other staff members with the GP partners that were dismissed, and no actions were taken. There had been a lack of action taken in response to health and safety risk assessments to ensure staff safety at all times, particularly at the branch site. We were informed the branch site had been closed during the COVID-19 pandemic and had not been re-opened for long when we carried out the inspection. There was a Freedom to Speak Up Guardian who was one of the GP partners. Not all staff were aware of who this was although it was documented in the Whistleblowing policy. There was no one independent of the GP partners or practice management for staff to go to to speak up. The training records showed that 20 out of 58 staff members had completed equality and diversity training.	

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

Source	Feedback
--------	----------

Staff interviews and feedback forms	<p>Staff feedback about working at the practice was predominantly negative. Staff reported that communication channels between staff and managers were not always sufficient with a reliance on email communication rather than face to face. Staff were not invited to meetings and were not included in the minutes distribution, so they were not always aware of the learning from significant events and complaints.</p> <p>We were informed that there had been a lot of staff leave over the previous months. They stated new staff had been recruited but training for them was not sufficient and mistakes were being made.</p> <p>Some staff reported there had been changes made to their job roles without consultation.</p> <p>Newer members of staff who provided feedback were more positive regarding the practice management.</p>
-------------------------------------	--

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
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.	N
<p>Explanation of any answers and additional evidence:</p> <p>There was a lack of oversight of governance structures and systems. For example,</p> <ul style="list-style-type: none"> The practice did not have an overview of all training completed by staff. The training log showed online training completed and had many gaps where staff had not undertaken essential training. There was no record of any face to face training that had been completed. The Induction, Statutory and Mandatory Training policy did not contain details of what training the practice considered mandatory and there was no outline of the induction process. There was no overview of pre-employment checks. The practice did not have a record of which staff had received a Disclosure and Barring Service (DBS) checks or who had received vaccinations in line with current UK Health and Security Agency (UKHSA) guidance. The practice had a recruitment and selection process and policy. There was no reference in either document to regarding guidance for managers to follow in relation to pre-employment checks of staff vaccination status. There was a lack of oversight to ensure policies and procedures regarding medicines management and effective management of patients was applied. <p>There was a lack of oversight to provide assurance that the backlog of summarising of new patient notes was being addressed with a plan of action in place to clear it.</p>	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
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
<p>Explanation of any answers and additional evidence:</p> <p>Processes for medicines reviews were not always followed. The provider was unable to demonstrate effective clinical oversight of staff working in the practice, in particular, non-medical prescribers. Risk assessments had been completed but there were no action plans in place to address areas that required attention. Managers were unable to demonstrate clear oversight of risk assessments to ensure actions required were being followed up. We were informed at the inspection that health and safety risk assessments and infection control audits had not been completed for the branch site. After the inspection, documents were produced by the practice to suggest these had been completed. The practice did not have a quality improvement programme in place. They had undertaken 3 single cycle audits. There were no completed audits to demonstrate quality improvement.</p>	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

Governance and oversight of remote services

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

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.	Partial
The practice had an active Patient Participation Group (PPG).	Y
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had started to use the NHS Friends and Family Test (FFT) to gather feedback from patients. They had been collecting feedback for 4 weeks, however, they had not analysed the results at the time of the inspection to improve services. Actions had been taken in response to complaints.</p> <p>There were currently 4 members of the PPG who met 4 times a year. There was information on the practice website that encouraged new members to join. The practice identified different population groups they would like to join to provide a full representation of the practice patient profile.</p> <p>Staff had been asked to provide feedback on the practice. They were asked to document on white boards in the staff rest room area their thoughts on what was working well and what wasn't working well.</p>	

Feedback from staff during interviews and from staff feedback forms was that they were not involved in changes being made at the practice.

Feedback from Patient Participation Group (PPG).

Feedback

Feedback from the PPG was positive regarding the practice and how they listened to the group. We were informed that the practice manager and a GP partner attended the meetings. The PPG felt the practice was open and honest.

The group had provided feedback about telephone access and felt there had been some improvements made in the previous 2 months.

We were informed that the PPG found the practice caring and the GPs and nursing staff helpful.

Continuous improvement and innovation

There was some 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.	N
Explanation of any answers and additional evidence: The practice used significant events and complaints to learn and make improvements. We noted these were generally managed well. However, the significant event forms did not contain documentation of the outcomes and learning. These were recorded in the minutes of the clinical governance meetings. Not all relevant staff were invited or able to attend the clinical governance meetings. The minutes of the meetings were not shared with all staff.	

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)	≤ -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.