

Inspection Evidence Table

The Acton Health Centre

(1-9375293570)

Inspection Date: 31 May 2023 & 1 June 2023

Date of data download: 12/05/2023

Overall rating: Good

Safe

Rating: Good

At the previous inspection in May 2022, we rated the practice as requires improvement for providing safe services because:

- Recruitment checks including Disclosure and Barring Service (DBS) were not always carried out in accordance with regulations.
- Some staff had not received safeguarding children, safeguarding adults, sepsis awareness, chaperone or fire safety training relevant to their role.
- Our clinical records searches showed that the practice did not always have an effective process for monitoring patients' health in relation to the use of medicines including high risk medicines.
- Blank prescription forms were not recorded, and their use was not monitored in line with national guidance.
- Risks to patients were not assessed and well managed in relation to some safety alerts, some emergency medicines, staff vaccination and the monitoring of the repeat prescription box for uncollected prescriptions.
- Actions from recent fire and legionella risk assessments were not completed in a timely manner.
- A defibrillator was not correctly stored, and an appropriate poster was not displayed. Some non-clinical staff we spoke with were not sure about the exact location of the defibrillator.

At this inspection in May 2023, we found improvements had been made. We rated the practice as **Good** for providing safe services.

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.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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> <ul style="list-style-type: none"> • Staff had received safeguarding children, safeguarding adults, infection control and fire safety training relevant to their role. • There was a Female Genital Mutilation (FGM) policy in place. The clinical staff members we spoke with demonstrated a satisfactory understanding to report cases of FGM including considering the potential risk to other girls in the family as they may need to be safeguarded from harm. • Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). All clinical staff had received an 'enhanced' DBS check. 	

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> <ul style="list-style-type: none"> • At the previous inspection in May 2022, we found that the recruitment checks including Disclosure and Barring Service (DBS) were not always carried out in accordance with regulations and records were not kept in staff files. • At this inspection in May 2023, we reviewed two staff files and found that appropriate recruitment checks had been undertaken prior to employment. • Staff vaccination was maintained in line with current UKHSA guidance. • All clinical staff had appropriate medical indemnity insurance in place. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 25 June 2022.	Y
There was a fire procedure.	Y
Date of fire risk assessment: 6 September 2021.	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice was renting space in shared premises and the host was responsible for managing the premises. Actions from the recent fire risk assessment were identified and the practice had addressed the issues related to the areas occupied by the practice. We noted some actions were still not completed. However, the practice informed us that they were not related to the areas occupied by the practice. We noted the practice was in discussion with the host to ensure that the remaining actions were completed by the host who was responsible for managing the premises in a timely manner. • There was a documented fire evacuation plan in place specific to the practice. • Staff had received fire safety training. • The fire system was regularly serviced and there was a record of fire alarm checks. • The practice carried out fire drills twice a year and maintained the list of staff who took part in fire drills as required by their fire risk assessment. • The fire system was inspected in February 2023. • Emergency lighting was inspected regularly. • A Health and safety policy was in place. • A gas safety check was carried out in January 2023. • Portable appliance testing was carried out in September 2022. • There were records of equipment calibration which was carried out in June 2022. • The fixed electrical installation checks of the premises had been carried out on 27 January 2022. 	

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.	Y
Date of last infection prevention and control audit: 17 April 2023.	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: <ul style="list-style-type: none">• Clinical equipment was cleaned on a regular basis and records were maintained.• We saw a cleaning schedule was in place and records were maintained.• The practice had an up-to-date legionella risk assessment (18 July 2022) in place and regular water temperature checks had been carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).• Actions from the recent legionella risk assessment were identified. However, the practice informed us that they were not related to the areas occupied by the practice.	

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: <ul style="list-style-type: none">• The practice operated a system to organise annual leave and cover for unexpected absences.• All requests for home visits were triaged by the duty GP.• There was public awareness information on the practice's website.• All staff had received sepsis awareness training.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> A review of patient records in relation to the clinical searches identified that most care records were managed in a way to protect patients. However, we found that some required tests were not carried out in a timely manner. Our findings are discussed in detail in the section below. 	

Appropriate and safe use of medicines

The practice had 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	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.51	0.63	0.86	Variation (positive)
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). (01/01/2022 to 31/12/2022) (NHSBSA)	5.7%	8.1%	8.1%	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 (01/07/2022 to 31/12/2022) (NHSBSA)	5.71	5.50	5.24	No statistical variation

Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	52.5‰	58.1‰	130.3‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.56	0.44	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	5.7‰	4.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. 1	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
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

Explanation of any answers and additional evidence, including from clinical searches.

At the previous inspection in May 2022, our clinical records searches showed that the practice did not always have an effective process for monitoring patients' health in relation to the use of medicines including some medicines that require ongoing monitoring. At this inspection in May 2023, we found the practice had demonstrated improvements. However, our clinical records searches found some issues and further improvements were required. For example:

- We found that monitoring for patients prescribed methotrexate (used to treat inflammatory conditions) was not always managed appropriately. We reviewed three patients being prescribed this medicine, which required patients to receive regular blood test monitoring. We found 1 patient did not have their blood test in a timely manner, and they were overdue by 3 weeks.
- We reviewed 5 patients with asthma who had been prescribed 2 or more courses of oral steroids in the last 12 months and found 1 week follow up was not carried out for all 5 patients after prescribing steroids.
- We reviewed 5 patients prescribed direct oral anticoagulants (DOAC) medicine, which referred to a group of anticoagulant medicines that are used to treat or prevent blood clots. We found that 1 patient did not have their blood test in a timely manner, which helped to provide information about how well the kidneys were working. The practice had sent multiple invites to the patient to attend for monitoring. However, they were not short scripted in line with guidelines in this situation (that is, their prescription reduced until the monitoring was carried out).
- A few days after the inspection, the practice submitted an action plan to address the clinical issues identified during the inspection. The practice assured us that these patients would be contacted and followed up.

In addition, at the previous inspection in May 2022, we found:

- Blank prescription forms were not recorded, and their use was not monitored in line with national guidance.
- Some emergency medicines were not kept in stock and the monitoring of the repeat prescription box for uncollected prescriptions was not effective.
- A defibrillator was not correctly stored, and an appropriate poster was not displayed. Some non-clinical staff we spoke with were not sure about the exact location of the defibrillator.

At this inspection in May 2023, we found:

- We found that blank prescription forms for use in printers were recorded and tracked through the practice, and their use was now monitored in line with national guidance.
- Appropriate emergency medicines were kept in stock and regularly checked.
- The practice had an effective system to support vulnerable patients with requesting and collecting prescriptions. This involved checking the prescription box regularly and contacting the patient to check if they still required the medicine or if a new prescription was issued.
- A defibrillator was correctly stored and regularly checked, and an appropriate poster was displayed. The staff we spoke with were aware of the exact location of the defibrillator.
- The practice had an effective system to identify and monitor who was collecting the repeat prescriptions for controlled drugs from the reception.
- The practice worked closely with the local area medicines management team regarding the safe prescribing of antibiotics, within national guidance, and medicines optimisation.
- Vaccines were appropriately stored in the fridge and fridge temperatures were monitored regularly. The practice had a secondary thermometer in the fridge used to store vaccines, which logged all the data and provided assurance that temperatures had been within the required range, as recommended in Public Health England guidance.

Track record on safety and lessons learned and improvements made
The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	6
Number of events that required action:	6
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw in staff meeting minutes that significant events were discussed and documented. The staff we spoke with informed us that learning from significant events had been shared with them on a regular basis. 	

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

Event	Specific action taken
Data breach	The practice investigated the incident, which involved a document sent to the wrong patient. The practice implemented necessary actions and reviewed the staff email process.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was an effective system in place to receive and share all safety alerts. If any action was required, this was assigned to an appropriate member of staff and it was recorded when the action was completed. We saw examples of actions taken on recent alerts, for example, regarding sodium valproate. 	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	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 had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">We found that the practice was generally reviewing and updating records effectively. However, our clinical records searches found some issues related to the use of medicines including methotrexate and direct oral anticoagulants (DOAC) medicine. The practice provided assurance that these cases were being followed up immediately following the inspection.	

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. There was an appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with 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

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Patients with asthma were offered an asthma management plan. However, during our clinical records searches, we found some areas where improvement was required. For example, we noted that one week follow up was not carried out for after prescribing steroids for 5 patients we reviewed.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in the hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	45	55	81.8%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	47	52	90.4%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	46	52	88.5%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	46	52	88.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	24	31	77.4%	Below 80% uptake

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
<ul style="list-style-type: none"> We noted that the practice demonstrated improvement in childhood immunisations uptake compared to the previous inspection in May 2022. Childhood immunisations were carried out in line with the national childhood vaccination programme. However, childhood immunisation uptake rates were below the World Health Organisation (WHO) targets for all 5 of immunisations measured in 2021/22. The practice explained that this was due to the transient population and challenges within the practice. For example, the practice identified that some children were not living in the country or had childhood immunisation carried out in their native countries, but this information was not shared with the practice. The practice had taken steps to improve childhood immunisation uptake. The practice conducted a thorough analysis of the data and identified targeted areas to improve performance. The practice had maintained a register and a dedicated staff was contacting the parents or guardians of children and encouraging childhood immunisation uptake.

- The practice informed us they supported the polio booster campaign (2022) by contacting and offering those children eligible for the booster in addition to routine immunisations and catch up for those unimmunised.
- The practice informed us there was a high refusal rate for immunisation for measles, mumps and rubella (MMR).
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up on failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- The practice nurse had received regular annual training updates relevant to childhood and travel immunisations.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	52.6%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	55.2%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (30/09/2022 to 30/09/2022) (UKHSA)	55.3%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	20.0%	55.1%	54.9%	No statistical variation

Any additional evidence or comments

- The practice population uptake rates for national cancer screening programmes were below the England average.
- The practice explained that this was due to the transient population, ongoing pandemic restrictions and known cultural challenges within the practice population, which had an impact on the cervical cancer screening uptake.
- The practice had taken steps to encourage uptake. For example, the practice informed us that they were actively involved with cervical screening and offered out of hours clinic to promote and encourage patients to have the test done. They had allocated a dedicated session for the practice nurse to call and invite patients which resulted in better uptake of the test.
- There was a policy to offer telephone reminders and send text messages to patients who did not attend their cervical screening test. All non-attendance was flagged on the patient's record so that the

clinicians opportunistically encouraged patients to make their appointments. However, further improvements were required to meet the 80% coverage target for the national screening programme.

- The practice had a system to ensure results were received for all samples sent for the cervical screening programme. The practice had established failsafe systems to follow up women who were referred to as a result of abnormal results.
- We noted a practice nurse had received specific training on sample taking for the cervical screening programme in order to improve uptake.
- The practice was aware of the low uptake in bowel cancer screening. There was a policy to send text messages to patients. The practice informed us there was a high refusal rate due to known cultural challenges within the practice population.

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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> • The practice carried out repeated clinical audits to review and monitor the appropriateness of high-risk medicines prescribed. The aim of the audit was to identify and ensure appropriate documentation and effective monitoring including appropriate dosage, length of supply and appropriate frequency of prescribing in line with local and national guidelines. • The practice had carried out a clinical audit of urea and electrolytes test requests for patients prescribed Mirabegron treatment to ensure patient safety. (Mirabegron medicine is used to treat the symptoms of an overactive bladder). 	

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• All staff received annual appraisals in a timely manner.• Staff had received safeguarding children, safeguarding adults, sepsis awareness, chaperone and fire safety training relevant to their role.• We noted practice nurses had received regular annual training updates relevant to travel immunisations and childhood immunisations in the last 12 months.	

Coordinating care and treatment

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

	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: <ul style="list-style-type: none">• The practice acted on communication from external services to maintain continuity of 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: <ul style="list-style-type: none">• Staff we spoke with described how patients were referred to other services, for example, to the health visitor, social services and social prescriber.	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence, including from clinical searches: <ul style="list-style-type: none">• Our clinical review of notes where a DNACPR decision had been recorded, identified that where possible the patients' views had been sought and respected. We saw that information had been shared with relevant agencies.	

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none">• The practice understood the needs of its population and tailored services in response to those needs. For example, the practice was proactive in offering online services, which included online appointment booking; an electronic prescription service and online registration.• The practice made reasonable adjustments when patients found it hard to access services. For example, there were accessible facilities, which included a hearing loop and a disabled toilet.• The practice website was well designed, clear and simple to use featuring regularly updated information. The practice website included a translation facility.• The practice sent text message reminders of appointments.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am-6.30pm
Tuesday	8am-6.30pm
Wednesday	8am-6.30pm
Thursday	8am-6.30pm
Friday	8am-6.30pm
Appointments available:	
Monday	9am-5.30pm
Tuesday	9am-5.30pm
Wednesday	9am-5.30pm
Thursday	9am-5.30pm
Friday	9am-5.30pm
Extended hours opening (Offered by the local Primary Care Network):	
Monday to Friday (at local GP Access centres/ hubs)	6.30pm-8pm
Saturday (at local GP Access centres/ hubs)	9am-5pm
Saturday (at local GP Access centres/ hubs)	9am-1pm

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.
- Extended hours appointments were available on Saturdays and Sundays for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Pre-bookable appointments were also available to all patients at additional locations within the area. Extended appointments were available Monday to Friday 6.30pm until 8pm and Saturday and Sunday. (Offered by the Primary Care Network at local hubs).
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Appointments were offered and undertaken by telephone, video consultation and on a face-to-face basis. • The practice informed us they supported access for people with different communication needs. For example, the use of interpretation services during consultations when required. • The practice had identified patients who were vulnerable or who would have difficulties accessing the service and had flagged them on their computer system. They would offer those patients home visits as a priority. • In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them. 	

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	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)	68.1%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	53.5%	58.2%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with	60.6%	58.9%	55.2%	No statistical variation

their GP practice appointment times (01/01/2022 to 30/04/2022)				
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	64.1%	68.5%	71.9%	No statistical variation

Any additional evidence or comments

- The practice had 4,320 patients registered with the practice. On the day of the inspection, we found the practice offered 13 GP clinical sessions per week.
- We noted clinical pharmacists (employed by the primary care network) offered two clinical sessions at the practice.
- The practice was offering a phlebotomy clinic onsite.
- The practice had identified patients who were vulnerable or who would have difficulties accessing the service and had flagged them on their computer system. They would offer those patients home visits as a priority.

Source	Feedback
Discussion with the patient participation group (PPG) members and a patient	<ul style="list-style-type: none"> • Two PPG members and a patient we spoke with praised the practice for efficiently adapting the service in line with the evolving pandemic, whilst maintaining an accessible and supportive service. • They informed us that the practice had taken steps to improve access to the service. • They were satisfied with the online access provided by the practice.

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.	4
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
Customer service skills	The practice investigated the complaint and apologised to the patient. The practice offered customer service training to all staff members and reminded all staff to follow the correct protocol.

Well-led

Rating: Good

At the previous inspection in May 2022, we rated the practice as requires improvement for providing Well-led services because:

- There was a lack of effective governance in some areas, which included monitoring of some high risk medicines, safety alerts, some emergency medicines and equipment, recruitment checks and monitoring of blank prescription forms.
- The Patient Participation Group (PPG) was not active.

At this inspection in May 2023, we found improvements had been made. We rated the practice as **Good** for providing Well-led services.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Staff we spoke with were complimentary about the leadership at the practice. We were told that the leaders were approachable, supportive and inclusive. Staff told us this made them feel motivated.• The practice's CQC registration was up to date.	

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

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

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

Source	Feedback
Staff feedback	<p>We spoke with a mix of staff during the inspection:</p> <ul style="list-style-type: none">• All the staff interviewed reported a positive experience of working at the practice.• Staff described a positive learning environment where they were supported and encouraged to complete training and professional development.• Staff felt they were treated equally.• We were informed that the practice culture was one of being open and supportive of one another.• Clinical staff said they had prompt access to the senior GP when they needed clinical advice.

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: <ul style="list-style-type: none">• The practice demonstrated improvements in governance arrangements compared to the previous inspection in May 2022.• There was a clear organisational structure and staff were aware of their own roles and responsibilities. There was a range of practice specific policies which were available to all staff. These were reviewed annually and updated when necessary.• There were a variety of daily, weekly and monthly checks in place to monitor the performance of the practice.	

Managing risks, issues and performance

There were clear and effective processes for managing most risks, issues and performance. However, some improvements were required.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There were processes to ensure risks to patients were assessed and well managed in most areas, with the exception of those relating to the monitoring of some high risk medicines.• The practice had implemented excellent processes to monitor clinical performance and quality of care within the practice.• The practice had a business continuity plan in place.	

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.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Patients had a variety of means of engaging with the practice all of which were effective: text messages, emails and complaints/comments.• Staff feedback highlighted a strong team with a positive supporting ethos.• Staff said the leadership team proactively asked for their feedback and suggestions about the way the service was delivered. Staff meetings were held regularly.• The practice worked closely with their Primary Care Network (PCN). This was particularly evident at the onset of the pandemic when communication with the PCN was frequent.	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none">• There was an active Patient Participation Group (PPG) that met on a regular basis and submitted proposals for improvements to the practice management team. For example, the practice started offering phlebotomy (to take blood from a vein) services in-house in October 2022.• We spoke with 2 PPG members and they were positive about the care and treatment offered by the practice, which met their needs.• Feedback from the PPG members about the service and staff was positive. They told us that their views and ideas were listened to and accommodated as much as possible.• They said the staff were caring and the receptionists were friendly and helpful.

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

Examples of continuous learning and improvement

- The practice took the initiative to tailor the support provided to the clinical team including overseas trained doctors, nurses and other healthcare professionals and coached them and supported them to join various roles in the NHS.
- The practice enabled homeless people to register at the practice address and signposted them to two local charities.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- All staff received individualised training opportunities which were discussed at their appraisals. The practice used this information to inform its overall training plan.

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

Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.