

Care Quality Commission

Inspection Evidence Table

Dr A Bisarya (1-575924221)

Inspection date: 10 & 12 October 2022

Date of data download: 03 October 2022

Overall rating: Good

Safe

Rating: Requires Improvement

The practice was rated requires improvement for providing safe services because systems and processes in place to assure them that both patients and staff were safe in the working environment were not fully effective. We found gaps in the assurance systems relating to the management of risk that the practice had in place. The practice had re-addressed some of these concerns immediately with NHS property services to ensure a resolution. We also found that some patients had not had the appropriate level of monitoring completed, which the practice also added to their action plan.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. There were gaps in some systems that we identified.

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

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.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice was unable to demonstrate that staff immunisations were recorded. Leaders we asked told us that the practice did not offer immunisations to staff.</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: October 2022	Y
There was a fire procedure. Date of fire risk assessment: March 2022	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice operated from a building run by NHS property services who conducted environmental risk assessments. The practice had systems in place to gain assurances from them that these were completed and to a standard that ensured patients safety. We found that these systems were not fully effective.</p> <p>In the fire risk assessment provided by NHS property services, it stated that ceilings were intact and in good repair, we found that this was not the case and ceiling tiles were missing and some were in need of repair. We also found that one fire door was too big for the frame and did not shut. The checklist completed by the practice to gain assurances stated that all fire doors, walls and ceilings were in a good state of repair.</p> <p>The fire risk assessment conducted by NHS property and the practice checklist stated that door wedges were not used, but we found that door wedges were present throughout the building. The practice assured us verbally that these were not used but could not explain why they were present near doors throughout the property.</p> <p>We found that the practice had a fire logbook that showed that fire drills were in place and were last conducted in December 2021, fire extinguishers had last been serviced in July of 2022.</p> <p>We saw that both portable appliance testing and calibration checks had been completed in October 2022.</p> <p>Following the inspection, the practice provided additional information which showed that they were aware of the damaged and missing ceiling tiles as well as the ill-fitting fire door. They were able to provide evidence that the damaged or missing ceiling tiles had been reported to the property management prior to the inspection in September and October 2022. The date provided for the repairs of the ceiling tiles was the 20th October 2022.</p> <p>Also following the inspection, the practice provided a fire risk assessment from October 2022 that had identified the ill-fitting fire door. This had not been actioned by NHS property services or picked up by the following risk assessment conducted in March 2022. The practice had taken no action from October 2021 to follow-up or ensure this work was completed.</p>	

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 (IPC).	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: May 2022 (practice checklist)	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice could not fully demonstrate the effectiveness of their systems of assurance in relation to IPC, we found that in their assurance checklist there were large areas where the practice had not sought assurances due to NHS property services having responsibility for them such as toilets and baby changing areas. We asked the practice about this who told us that they did check but they didn't record these checks. We asked for the main IPC audit conducted by the landlords of the property and the practice sent us cleaning logs that were conducted by the cleaning staff employed by the landlord. The practice showed us a five-star rating for cleanliness that had been awarded to the health centre in July 2022. The practice told us that they completed informal "walk around" checks to ensure oversight of cleaning. We found evidence that cleaning standards were not appropriate. For example, we found visible dirt and dust on handrails, overflowing dirty pedal bins; we also found visible dirt on sinks.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>Reception staff were provided with a protocol that allowed them to make decisions about "next steps", should they encounter patients on the telephone with worsening symptoms. This was detailed but did not include information in relation to sepsis. We asked leaders about this, who told us that sepsis symptoms were on posters for staff to refer to. We saw these posters were in place. The practice told us they would add sepsis symptoms to the protocol to ensure staff were fully aware of what to do should they encounter these symptoms.</p> <p>Staff we spoke with told us that staffing could be tight at times, leaders we spoke with outlined their current recruitment of staff to address this. The practice also informed us that they were moving away from the locum model they had had towards having more permanent clinical staff as part of their business continuity and succession planning.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation but these were not always fully effective.

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)	0.81	0.82	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)	6.8%	8.9%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.42	5.54	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	177.8‰	187.5‰	128.0‰	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>	0.09	0.48	0.59	Significant Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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.	Partial
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.	

Medicines management	Y/N/Partial
<p>The practice was unable to demonstrate that medicine reviews had always been completed within guidance or contained sufficient information to be regarded good practice. We highlighted this to the practice who provided us with an action plan to address this complete with dates for completion and who was responsible for ensuring the action was completed.</p> <p>The practice was not always able to demonstrate that all patients who required monitoring had received it in a timely manner. We found two of three patients on Lithium (a type of medicine known as a mood stabiliser) had not had calcium in their blood checked, one at all and the other since January 2021. Records we reviewed confirmed this. The practice told us that they were not aware that calcium needed to be checked.</p> <p>Our headline search also showed that although all 61 patients on DOACs (Direct Oral Anti-Coagulants) had had some testing of their bloods completed, eight of these patients had not had all tests completed. Of the 420 patients on ACE (angiotensin converting enzyme – a type of medicine that reduces blood pressure), 34 were overdue monitoring, one of the five patients on amiodarone (a medicine used to treat problems with the rhythm of the heart) was overdue monitoring and three of the 18 patients on aldosterone antagonist (a medicine that increases the output of urine from the body), were also overdue. We did not review records in relation to these patients but asked the practice to review our searches and provide us with assurances for these patients. The practice confirmed our search results and produced an action plan to address these gaps by the end of November 2022. The practice had monitored all its patients on Disease-modifying anti-rheumatic drugs (DMARDs) (used to treat rheumatoid arthritis) and those on warfarin (an anticoagulant medicine).</p> <p>The practice did not have controlled drugs on the premises.</p> <p>The practice did not hold all recommended emergency medicines and had risk assessed their business and clinical decisions not to hold these medicines. We reviewed the risk assessment and found that it would benefit from clarification. For example, the risk assessment stated that ambulance call out times would probably be short, but the practice had not completed any tests of this or reviewed the times to ensure that this remained accurate. The practice told us that this would be addressed.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong but felt further development was needed.

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:	

The practice had a system for recording significant events that included setting out the investigation, learning outcomes and actions. The practice told us that they were expanding their criterion for what would constitute a significant event as they explained that the threshold would benefit from being lowered to include more events that could contribute to learning.

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

Event	Specific action taken
Unable to contact patient	In response to this the practice sent a paramedic to the address to conduct a welfare check. This led to a positive outcome for the patient.
Two week wait referral	Two separate two week wait referral incidents had taken place and the practice systems of consultation and notes auditing had picked up these concerns quickly and they were addressed.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a system in place to identify and disseminate information in relation to safety alerts. They were also able to address these concerns directly with patients, but we found that this was not always effective. We found that 12 female patients of childbearing age who were prescribed teratogenic medicines (those that may cause deformities to unborn children, if administered to pregnant women; for example, pregabalin), had not been provided with warnings. We also found that 42 patients who were prescribed SGLT2 inhibitors (diabetic medicine) that could cause a serious infection called Fournier's Gangrene, were not informed of the dangers. The practice added these patients to the action plan they produced ensuring that all patients were reviewed either by monthly audit or by the PCN (Primary Care Network) employed clinical pharmacist. The practice also committed to ensuring that all clinicians were informed about these risks to ensure that warnings were given before commencing these medicines in the future.</p> <p>Following the inspection, the provider told us that of the 42 patients identified in our headline search, 16 had already been spoken to by a clinician about possible side effects relating to the British National Formulary but not in relation to the safety alert, which was issued in February 2019. The practice further told us that these alerts had now been fully actioned.</p>	

Effective

Rating: Good

The practice was rated good for providing effective services because although gaps were identified in some areas, the practice had achieved a good standard of care delivery in the majority of areas. Those areas that were in need of further development were known by the practice, who had strived to address them within their agency to do so.

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

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance but there were gaps that required addressing.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: We found that in the records we reviewed the majority of patients' needs were fully assessed, but we found that some patients had not had appropriate monitoring of their medicines. We also found that medicine reviews had not been completed to a sufficient standard indicated by national guidance. The practice had added this to a comprehensive action plan during the inspection to ensure that these were addressed in a timely manner.	

Effective care for the practice population

Findings

- The practice had begun using an online tool to access consultants in secondary care to speed up assessment of patients in the referral process. They told us that this service was effective and had positive outcomes for patients.
- The practice demonstrated that they had high utilisation of Macmillan services locally in proportion to their population size. Of the 16 referrals made in July to September 2022, from 15 practices locally, the practice had made three referrals. The practice population size was 2768, other practices included in this data had more than 18000 patients.
- 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 appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check. The practice told us that in the last year, out of 23 eligible patients, 17 had had reviews, which is 74% of this group. Of these 17 reviews, 94% were face to face appointments. The outstanding reviews were due to patients not attending or being unable to engage with this process. The practice continued to engage with these patients to encourage them to attend wherever possible.
- 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 shared an audit of patients that had passed away that helped them to understand if patients wishes had been adhered to wherever possible. Of the 25 patients listed, 11 had passed away in their preferred place, but 10 others did not have a preferred place identified. The practice told us they strived to ensure these preferences were recorded where possible.
- 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

- Following our review of clinical records, we identified three patients that had potential missed diagnosis of diabetes, one of which the records confirmed should have had a diagnosis.
- Our headline search identified 12 patients with “high-risk” diabetes (those patients that were in danger of retinopathy); we reviewed five records and found that four patients had blood pressure recorded on their notes and one patient was not attending for follow-up. Only one patient of the five had a full diabetic review in the past 12-months and none had had a diabetic medicine reviews completed. The practice committed in their action plan to reviewing all 12 patients on their list to ensure that all had reviews in place and add to their monthly searches to ensure that this continued appropriately going forward.
- We also identified four out of 101 patients with hypothyroidism (underactive thyroid gland) that had not had appropriate monitoring completed of their bloods. The practice added these patients to their action plan to ensure that going forward all of these patients had appropriate monitoring.

- For those patients with suboptimal control of their asthma, we identified nine patients on our headline search as having 12 or more SABA (short-action Beta antagonist) inhalers. We reviewed five records and found that all patients had had a review in the last 12 months, but this consisted of issuing these patients with a questionnaire about their asthma. These patient's completed questionnaires were used as confirmation of good control of their asthma but was not cross referenced with the data in relation to the high usage of inhalers (which demonstrated sub-optimal control). The practice committed to ensuring that these are brought together for a more comprehensive review of these patients going forward.
- For those asthma patients who had received more than two courses of prednisolone (a steroid medicine that helps reduce swelling and calm the immune system), we identified seven in our headline search and reviewed five records. We found that these patients were well managed at the time of their exacerbation.
- Of the 10 patients our headline search identified with severe CKD (chronic kidney disease), two were showing as overdue monitoring. We reviewed these records and found that both had been managed appropriately and were managed well overall.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Patients with COPD were offered rescue packs. Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	17	19	89.5%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	25	28	89.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for	25	28	89.3%	Below 90% minimum

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)				
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)	25	28	89.3%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	24	24	100.0%	Met 95% WHO based target

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

Any additional evidence or comments

The practice was aware of their lower than average immunisation results and explained the results were impacted due to the small number of eligible children. The practice showed us evidence that one of these patients' parents had refused immunisations and this had been recorded on the practice records. There were no plans to further address this, although conversations had taken place between parents of these children and the practice. Appropriate referrals had been made to health visitors.

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)	79.1%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	12.9%	59.0%	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)	52.7%	58.9%	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)	76.9%	54.8%	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 had not fully met the national target for cervical screening and were below national and local averages in relation to breast screening. We asked the practice about this who explained that for cervical screening, they would continue to educate patients as to the importance of the procedure and offer screening as conveniently as possible. They were not responsible for breast screening directly of patients but were informed by the screening service when patients did not attend (DNA). The practice sent text messages to these patients reminding them of the importance of breast screening. The practice had discussed their results with nearby practices that shared demographics but had better results in an attempt to understand how they might be able to address this but did not yet have formal plans in place. The practice also explained that the screening van that attended the area in the recent past, no longer did; the closest place for patients to get screened was more than 10 kilometers away.

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

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years.

The practice provided us with a number of clinical audits to demonstrate quality improvement activity including an adrenaline (a hormone and neurotransmitter) audit, a mirabegron (eases the symptoms of an overactive bladder) audit and a omeprazole and clopidogrel (used together to lower risk of heart attacks or strokes) audit, all of which were two cycle and demonstrated improved outcomes for patients. For example, of the nine patients who were prescribed adrenaline in August 2021, 66.7% had not had their appropriate prescriptions maintained; in March 2022 the number of patients prescribed this medicine had increased to 11 and all of these patients had the appropriate number of pens prescribed and maintained. In September 2021, of the 10 patients prescribed mirabegron, 70% had their blood pressure recorded; in August 2022, this number had increased to 13 patients, all of whom had blood pressure recorded on their records.

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: We saw that the practice took the oversight of staff seriously and had proactively established a system of supervision that involved consultation and treatment decision audits for clinical and non-clinical prescribers throughout the practice. This system was working as intended and had identified issues that were immediately resolved such as two examples of two week wait referrals that had been missed.	

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-centered care when they moved between services.	Y

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y

Consent to care and treatment

The practice systems for always obtaining consent to care and treatment in line with legislation and guidance, although they would benefit from strengthening.

	Y/N/Partial
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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.	Partial
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Partial
We reviewed 5 patient records with respect to DNACPR decisions and found that discussions had taken place, multiple professionals were involved and DNACPR forms were available. However, in all cases we found that patient capacity was implied, though not formally recorded and review dates had not always been placed on the forms or in the practice diary. Following our identification of this, the practice added it to their action plan which included all patients being contacted to have this information added to the records and embedded in future practice.	

Well-led

Rating: Good

The practice was rated good for providing well-led services because although there were some gaps identified in some areas; practice systems and processes were able to adapt quickly and responded immediately, demonstrating that overall, they had the capacity to deliver quality 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: Staff we spoke with were able to articulate their role and the role of leaders in the structures within the practice and were clear about how to raise concerns and contribute to learning and were comfortable in doing so. They told us that leaders were approachable and visible and leaders we spoke with confirmed that this was their intention.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice provided us with their statement of purpose which set out the practice vision and values; Collaboration, patient focused, respect and innovation, all within a context of accountability. Although this was a long-standing set of values, staff were on-board with it and understood its importance in generating an agreed way of working.	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	

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

Source	Feedback
Staff conversation	Staff we spoke with were happy working in the practice and felt that they were supported and had what they needed to complete their role and to raise concerns should they have any.

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.	Partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
The practice could not always demonstrate that their arrangements of assurance with property landlords was always fully effective.	
The practice reported that they did not have any backlogs other than those caused by delays in secondary care. They had continued to provide the same level of service delivery monitored against QOF (quality outcomes framework) expectations through the pandemic although these expectations were suspended.	

Managing risks, issues and performance

There were systems and processes for managing risks, issues and performance but these were not always fully effective.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
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: The practice was unable to demonstrate that assurance systems in place were fully effective, particularly in relation to managing environmental risks. The practice was made aware of this and assured us verbally that these areas would be addressed immediately. We saw that the practice had begun to address this immediately by contacting NHS property services about their concerns. We saw no evidence of any harm done to staff or patients that had resulted from these gaps in their systems of assurance.	

Appropriate and accurate information

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

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

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

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement

The practice demonstrated that they completed clinical audits, oversight and supervision of clinical and non-clinical prescribers in the form of audits and audits of patients that had passed away to ensure that their needs and preferences were met. There were areas that required addressing that were identified during the inspection and the practice responded immediately by producing a comprehensive action plan with proposed completion dates.

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.