

Inspection Evidence Table

Brook Medical Centre (1-5911679697)

Inspection Date: 15 November 2022

Date of data download: 01/11/2022

Overall rating: Good

At our previous inspection on 10 September 2021, we rated the practice as requires improvement overall and this rating remained unchanged following our interim inspection on 15 March 2022.

Following this inspection, the practice has been rated as Good overall. We found evidence to demonstrate the new management team had adopted a systematic approach to improvement. Previous concerns had been addressed and there was a comprehensive set of action plans in place to support continued improvements.

Safe

Rating: Good

At our previous inspection on 10 September 2021, we rated the practice as requires improvement for providing safe services and this rating remained unchanged following our interim inspection on 15 March 2022.

At the previous inspections we found:

- There was inadequate oversight of medicines management and safety alerts.
- Improvements were needed in relation to the management of some risks, for example, those relating to recruitment checks and stocks of emergency medicines held.
- Management oversight of staff completion of mandatory training required improvement.
- Records relating to staff vaccination had not been collated and there was no risk assessment in place to adequately assess and monitor associated risks.
- Clinical governance systems for the management of patients on medicines requiring routine monitoring were lacking.

At this inspection we found:

- There was evidence to demonstrate effective medicines management. Actions had been taken in response to safety alerts, including historic alerts predating the takeover.
- Previously identified risks in relation to recruitment, staff vaccination, staff training and emergency medicines had been removed through the implementation of new management systems.
- Comprehensive clinical governance systems had been developed and were being expanded to drive continuous improvement.

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
Explanation of any answers and additional evidence: At our previous inspection in March 2022, we found: <ul style="list-style-type: none">There were gaps in safeguarding training, for example 50% of staff required to complete level one safeguarding children training had done so (four out of eight staff, two of whom were new starters). 83% of staff required to complete level three safeguarding children had done so. Following this inspection, the practice advised a safeguarding training session for all staff had been arranged for 30 March 2022. At this inspection we found: <ul style="list-style-type: none">All staff had completed safeguarding training appropriate to their roles.A safeguarding task force had been formed to support effective management and oversight of safeguarding systems and concerns. We spoke with staff undertaking these roles who advised they were being supported through effective training and peer support to ensure they were competent and confident in their newly appointed posts.	

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
Explanation of any answers and additional evidence: At our previous inspection in March 2022, we found: <ul style="list-style-type: none">The practice had not taken the required action to ascertain staff vaccination status and risk assessments were still not in place. We were advised the practice was in the process of collecting	

relevant information from staff. We saw some evidence that this work was underway, for example vaccine records had been requested for recently recruited members of staff. Following our inspection, the practice submitted a staff vaccination policy which had been updated and reviewed on 17 March 2022. This policy determined the expectation for staff in different teams to be vaccinated for specific diseases. The policy also stated the practice would ensure staff who did not have the appropriate vaccination status received the necessary immunisations.

At this inspection we found:

- The practice utilized the local occupational health service to undertake screening for all staff to check their vaccination and immunity status, who undertook a tailored assessment for both clinical and non-clinical staff. The practice manager maintained a log for all staff to demonstrate they had completed the assessment with occupational health, which we were able to review during our inspection.

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: 19 May 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: 26 May 2022	Y
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: Since taking over the practice in April 2022, the current provider team had commissioned a full set of risk assessments. These included risk assessments for fire, health and safety and premises and legionella. Each of these risk assessments had identified multiple actions and areas for improvement. The management team had compiled comprehensive action plans in response to these audits and were able to demonstrate that items had been actioned according to priority and in some cases available funding. For example, emergency lighting had been installed throughout the premises. Although, there were still outstanding actions at the time of our inspection, these were being monitored on an ongoing basis with an overarching plan to complete actions as soon as possible.	

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: 12 May 2022	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

Explanation of any answers and additional evidence:

At our previous inspection in March 2022, we found:

- There had been improvements in the completion of infection control training with three members of staff still due to complete their training, one of whom had only recently been appointed. 85% of staff had completed level one training and 81% had completed level two training.

At this inspection we found:

- All staff had completed training in Infection Prevention and Control (IPC).
- The practice had undertaken a comprehensive IPC risk assessment with the support of the local Integrated Care System (ICS) quality team. The audit identified multiple areas for improvement and action. We saw evidence to demonstrate the practice had re-audited twice (on 20/09/2022 and 12/11/2022) and all priority items had been completed. At the time of our inspection, there were three items left awaiting completion, two of which had scheduled completion dates and the third of which was pending available funding.

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: The practice had developed an induction programme for new staff. At the time of our inspection, there was one new member of staff who would be the first to complete the recently developed programme.	

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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>At the time of our inspection, the practice advised they were aware there was a backlog of 1,181 (17.7%) note summarising records for new patients. In response to this, the new management team had drawn up an action plan and there was an active advert for the recruitment of a dedicated administrator to support the catch up.</p>	

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) (01/07/2021 to 30/06/2022) (NHSBSA)	0.80	0.86	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	10.4%	7.9%	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)	4.78	5.13	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	213.3‰	130.8‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.60	0.61	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	7.9‰	7.7‰	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.	NA
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 our previous inspection in March 2022, we found:

- There were significant gaps in the practice's approach to monitoring patients' health in relation to the use of high-risk medicines. Following our inspection, the practice provided assurance that actions were being taken to address the identified risks.
- Records viewed did not routinely include blood monitoring result for patients where monitoring had taken place in secondary care. Following our inspection, the practice advised that results would be downloaded into patient records to improve safety systems for medicines management.

At this inspection we found:

- Improved systems were in place to ensure effective medicines management and that risks to patient safety were minimised. The practice was supported by a dedicated medicines management team who ran regular searches of the clinical system and took appropriate action where necessary, including in response to safety and medicines alerts.
- Upon reviewing the stock of emergency medicines held we found a medicine used to treat patients experiencing a seizure was not available. The practice advised they had had difficulty sourcing stock of this medicine but that they had been able to place an order during our inspection. In addition, the practice did not have a nebuliser available. (A nebuliser is a machine that turns liquid medicine into a fine mist. It is used to support patients suffering an exacerbation of asthma). Patients then breathe in the mist through a mask or mouthpiece. We were informed that the previous nebuliser had been condemned and a new one was to be ordered. Shortly following our inspection, the practice was able to provide evidence to demonstrate the nebuliser had been ordered.

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 since May 2022:	22
Number of events that required action:	22

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

Event	Specific action taken
Breach to cold chain (management of medicines stored in fridges).	Staff were provided with appropriate training. In addition, a system was developed to regularly audit the cold chain to reduce the risk of recurrence.
Potential misdiagnosis/ safeguarding concerns.	The practice undertook an investigation to the incident, working with other professional bodies and actioning recommendations. Systems and protocols were updated, and multi-disciplinary team meeting attendance was expanded to prevent the risk of recurrence.

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
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in March 2022, we found:</p> <ul style="list-style-type: none"> We found that two separate safety alerts had not been actioned. However, during our inspection the practice took action to review identified patients and ensure prescribing was in line with safety recommendations. The practice also took action to ensure future safety alerts were actioned in a timely manner. <p>At this inspection we found:</p> <ul style="list-style-type: none"> There was evidence to support a systematic approach to responding to safety alerts and recording of actions taken. We reviewed action taken in response to a safety alert concerning teratogenic medicines. Records reviewed demonstrated appropriate action had been taken, included changing of medicines and updating of patients' records with warning information as required. 	

Effective

Rating: Good

At our previous inspection on 10 September 2021, we rated the practice as requires improvement for providing effective services and this rating remained unchanged following our interim inspection in March 2022.

At our September 2021 inspection we found:

- There was no structured process of staff supervision and support.
- There was no evidence of regular reviews of non-medical prescribers, prescribing practice or evidence that they were supported by clinical supervision to ensure safe and effective oversight of prescribing decisions.
- Non-clinical staff were not having their performance monitored in any formal way. There was no evidence of regular meetings with staff to assess their performance and provide support.

At our March 2022 inspection we found:

- An approach to clinical supervision had been introduced which incorporated regular review of the prescribing practice of non-medical prescribers.
- All but one member of the non-clinical staff team had received an appraisal.

At this inspection we found:

- There was evidence to demonstrate improvements made by the current provider team, including the development of quality monitoring and improvement systems to ensure effective monitoring of patient safety and medicines.
- Staff described improved management systems and all staff had received an appraisal.

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

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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.	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 had prioritised care for their most clinically vulnerable patients during the pandemic	Y
The practice prioritised care for their most clinically vulnerable patients	Y

Effective care for the practice population

Findings
<ul style="list-style-type: none"> • 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. The practice was able to refer patients to the primary care network (PCN) frailty team for assessment. • Health checks, including frailty assessments, were offered to patients over 75 years of age. • The practice supported patients in a local care home, providing face to face care and virtual ward rounds. • 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. • 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

- Patients with long-term conditions were offered an effective 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.
- The practice was in the process of training a member of the nursing team to support with reviews of patients with long-term conditions.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Remote clinical searches undertaken for patients at risk of developing diabetes did not identify any patients who had not already been contacted and/or supported by the practice.
- 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 where appropriate.

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)	61	68	89.7%	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)	61	68	89.7%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	62	68	91.2%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	63	68	92.6%	Met 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)	66	71	93.0%	Met 90% minimum

Any additional evidence or comments

We spoke to staff regarding the practice's performance for the child immunisations programme, as some indicators fell below the 90% minimum target. (The performance data predates the practice takeover). Staff discussed the practice system for encouraging uptake of children's immunisations which included sending a link to parents/guardians via SMS allowing them to book appointments at a convenient time. Staff were aware of the challenges facing some of the practice's patient population and responded to these by offering supportive calls and flexibility if appointments had been missed. Repeated failed attendances were monitored and safeguarding concerns raised if appropriate.

We noted the discrepancies in the performance data for children aged 2, with different data for each indicator, where the immunisations are usually all given in one appointment. The practice advised this was due to some patients having had some vaccines abroad and only needing some of the vaccinations when attending appointments.

Cancer Indicators	Practice	SICBL average	England	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). (30/06/2022 to 30/06/2022) (UKHSA)	68.5%	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) (01/04/2020 to 31/03/2021) (UKHSA)	59.4%	56.8%	55.4%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.5%	69.1%	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)	60.7%	64.4%	66.8%	N/A

Any additional evidence or comments

The practice was aware of lower performance for the percentage of patients attending for cervical screening. Staff informed patients were having to use the extended access service for cervical screening as there wasn't a suitably trained clinician available on site. The practice was aware that this was causing an increase in failed appointments. At the time of our inspection, one of the nurses was undergoing cytology training and a second nurse who was already trained in cytology had been recruited. It was envisaged that as soon as the service was available to patients from the practice there would be an improvement in uptake. Staff advised they were raising awareness through information in the practice, on the practice website and social media pages, as well as through direct and opportunistic conversations with patients.

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: We found the new provider team had undertaken multiple audits since taking over in April 2022, to assess practice systems, risks to patient safety and support identification of areas requiring urgent action. We reviewed an example of a two-cycle audit for patients taking medicines that required regular routine monitoring. The initial audit in July 2022 found gaps in monitoring processes affecting all patients. Immediate action was taken to reduce risks to patient safety. A second audit in September 2022 found all patients were receiving the appropriate care with monitoring and recall systems in place.	

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: At our inspections in September 2021 and March 2022, we found: <ul style="list-style-type: none">Gaps in staff training records.	

- Some staff had not received appraisals and there was limited evidence to demonstrate clinical supervision, including a review of prescribing practice for those requiring, for example, non-medical prescribers.

At this inspection we found:

- There was programme of regular clinical supervision for staff employed in advanced clinical roles, for example, non-medical prescribers.
- Staff were positive about newly implemented management systems. Staff we spoke with said they were well supported in their roles. Evidence was available to demonstrate all staff had received an appraisal.

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: The practice facilitated regular multi-disciplinary team (MDT) meetings to support patient care, particularly for vulnerable patients. Managers described how meetings had been expanded to include members of the district nursing team in the future.	

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 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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Y
Explanation of any answers and additional evidence: As part of our inspection, we reviewed DNACPR decisions made within the last 12 months. We undertook a random review of three records and saw that they were all detailed and comprehensive. We identified that decision forms had been retained and signed by an appropriate clinician. Care notes outlined how the decision had been discussed with patients, and how an assessment of the patient’s mental capacity had been undertaken. A flag had also been added to patient’s electronic records to indicate to staff that a DNACPR decision was in place	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

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

Patient feedback	
Source	Feedback
Patient feedback collected by the practice.	As part of our evidence gathering prior to the inspection, the practice provided a summary of patient compliments they had received. Patients complimented the approach of staff, noted improvements in provision and expressed gratitude for the quality of care received.
NHS Friends and Family Test	<p>The practice promoted and monitored patient feedback that was collected via the NHS Friends and Family Test results. This is a national feedback tool used within NHS services and asks people/patients if they would recommend the service they have used and offered a range of responses.</p> <p>Results from 29 September 2022 to 26 October 2022 showed that from 126 responses received, 53 patients were either extremely likely or likely to recommend the practice. Results also showed that 45 patients stated they were unlikely or extremely unlikely to recommend the service. The practice leadership team advised they envisaged improvements made to the telephone system, appointment availability and stabilising the management and clinical team would be reflected over time in patient satisfaction scores.</p>

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 stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	74.2%	82.7%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	80.3%	81.7%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	91.1%	91.4%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	55.4%	69.7%	72.4%	No statistical variation

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

Any additional evidence

The practice had undertaken an in-house patient survey in September 2022, receiving 174 responses from patients. Patients were positive about the quality of clinical care. However, there was some negative feedback relating to appointment availability and ease of making an appointment. At the time of our inspection, the practice team advised a new telephone system had been installed and the appointment system had been adjusted to try and improve patient experience.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

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 stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	81.8%	88.4%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	In November 2022, the practice patient population list was 6,577. The practice had identified 118 patients as carers; this amounted to 1.8% of the practice population.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> The practice's computer system alerted staff if a patient was a carer. New patient registration forms included information to highlight if patients had caring responsibilities. The register was validated annually and all carers were sent a carers information pack which included information on local support services
How the practice supported recently bereaved patients.	Staff told us that if families had suffered bereavement, the practice contacted them. Further advice was also offered as required and families were signposted to relevant support groups.

Privacy and dignity
The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

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

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	7.30am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8am to 1pm and 2pm to 6pm
Tuesday	8am to 1pm and 2pm to 6pm
Wednesday	7.30am to 1pm and 2pm to 6pm
Thursday	8am to 1pm and 2pm to 6pm
Friday	8am to 1pm and 2pm to 6pm

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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- 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, through the extended access service.
- 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 minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patients were able to book appointments in person or by calling the practice. The process for booking an appointment included an initial telephone triage carried out by clinician. Following this the most appropriate appointment based on clinical need would be arranged. This included either a face-to-face appointment or a same day emergency appointment. On the day of our inspection, we saw that same day appointments were available for those requiring urgent care as well as pre bookable appointments for those requesting routine appointments.</p> <p>The practice supported patients from a local traveller community. These patients had limited access to digital technologies and were supported to access services through methods more familiar and accessible to them.</p>	

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)	66.4%	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)	48.4%	55.4%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	53.5%	52.5%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	76.7%	72.2%	71.9%	No statistical variation

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.	15
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
Explanation of any answers and additional evidence: We saw there was a dedicated lead for handling complaints. Lessons learnt and improvements made were shared with staff and policies and protocols adapted if required.	

Example of learning from complaints.

Complaint	Specific action taken
Patient unhappy with care received.	The practice followed its protocol to investigate all elements of the complaint. Upon completion of the investigation the patient received a response. Actions were taken to reduce the risk of recurrence.

Well-led

Rating: Good

At our previous inspection on 10 September 2021, we rated the practice as requires improvement for providing well-led services and this rating remained unchanged following our interim inspection in March 2022.

At our previous inspections we found:

- A lack of effective governance systems, particularly those relating to monitoring of staff recruitment, emergency medicines and staff training.
- Clinical oversight to be lacking in relation to medicines safety alerts.
- Governance arrangements for safe medicines management were ineffective and risks were identified.

At this inspection we found:

- Evidence to demonstrate newly implemented clinical governance systems were operating effectively to reduce risks to patient safety and those associated with medicines management.
- Management systems introduced to ensure appropriate staff oversight, including recruitment and training were effective.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: Discussions with the leadership team demonstrated a clear understanding of the challenges to quality and sustainability, with multiple examples of active improvements made to the practice. For example, the leadership team had encouraged more integrated working with local partners, access to dedicated human resources support for staff and invested in new technologies to support day to day running of the service. Verbal and written staff feedback about the new leadership team was positive. Staff were positive about the benefits of receiving support from the central support centre which supported all the practices within the provider’s network of practices.	

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a mission statement, which was available on the practice website for patients. It stated: 'To help you to be well for the longest time and to preserve your dignity at life's end.'</p> <p>Staff we spoke with were aware of this and able to express how they worked as a team to support realisation of the practice's values.</p> <p>There was a business development plan which was regularly reviewed.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with were positive about improvements made by the new leadership team. They commented on the strong working relations between staff.</p>	

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

Source	Feedback
Staff feedback	Feedback from staff who worked for the service was positive. Staff reported a good working environment and a positive culture. Staff described leaders and managers as approachable and supportive, and felt comfortable in raising any concerns without fear of retribution.

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
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspections in September 2021 and March 2022 we found:</p> <ul style="list-style-type: none">• There was a lack of effective governance arrangements' which impacted on the delivery of key areas of care and treatment. In particular, monitoring of staff performance, arrangements for responding to medical emergencies, staff recruitment checks and staff training. There were also issues with governance arrangements to support safe and effective medicines management and oversight of staff vaccination programme. <p>At this inspection, we found:</p> <ul style="list-style-type: none">• The practice had developed a governance structure which outlined clear lines of accountability and responsibility for staff and patients.• The practice had nominated leads for key areas, such as safeguarding of adults and children and infection control, whom staff could contact for specialist advice and support. Staff understood their individual roles and responsibilities and knew who to contact if further advice was required.• There was a dedicated medicines management team and systems for ensuring patient safety in relation to medicines had improved.• All staff had received an appraisal and there was evidence of clinical supervision for staff non-medical prescribers.• Previously identified risks relating to staff recruitment and training had been removed.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: At our previous inspections in September 2021 and March 2022 we found: <ul style="list-style-type: none">• An overall lack of risk assessing at the practice. For example, risk assessments were not in place for staff who did not have the required vaccinations. At this inspection we found: <ul style="list-style-type: none">• The new management team had made many improvements to the management and oversight of risk. This included investment in externally commissioned risk assessments. In addition, there was evidence to support a systematic approach to internal risk assessment.• Where risk assessments resulted in identified actions, comprehensive action plans were available and evidence provided demonstrated these were regularly monitored and updated.• Audits demonstrated a commitment to quality improvement, particularly in regard to clinical care and medicines management.	

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
Explanation of any answers and additional evidence: Remote telephone consultations took place within closed clinic rooms to ensure patient confidentiality was maintained.	

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 (PPG).	N
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: At the time of our inspection, the practice did not have a PPG in situ. The practice was actively promoting membership of the group to try and encourage uptake from patients.	

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice team demonstrated a strong commitment to learning and continuous improvement. Staff we spoke discussed additional training they were receiving to support their own career progression whilst also improving the delivery of services for patients.</p> <p>We saw many examples of improvements made by the new management team, not limited to the areas previously identified as requiring improvement following our inspections in September 2021 and March 2022.</p>	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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