

Care Quality Commission

Inspection Evidence Table

The Everglade Medical Practice (1-2071557621)

Inspection date: 1 November 2022 and 24 November 2022

Date of data download: 15 December 2022

Overall rating: Requires Improvement

Due to whistleblowing concerns received, we carried out an unannounced comprehensive inspection at The Everglade Medical Practice on 1 November 2022. We continued the inspection with a second site visit on 24 November 2022. As a result of our findings, we rated the safe, effective, caring, responsive and well-led key questions as requires improvement, this gave the practice an overall rating of requires improvement. The provider took immediate action to address the concerns identified and introduced systems and processes to prevent recurrence. However, as these changes are new, they need to be monitored and become embedded in practice before we can be satisfied the concerns have been fully mitigated. Please see below evidences tables for more details.

Safe

Rating: Requires improvement

We rated the safe key question as requires improvement due to concerns relating to: infection prevention control; administration of Rotavirus vaccine; out of date and/or missing emergency medicines and equipment. We were also not satisfied the practice had appropriate systems and processes in place to ensure all policies, checklists and procedures were being regularly reviewed and updated.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse, however the safeguarding policy had not been recently reviewed or updated.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
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

Safeguarding	Y/N/Partial
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:	
During our first site visit on 1 November 2022, the practice was unable to locate an up-to-date safeguarding policy, the policy they had on their system was dated 2017. All staff we interviewed were able to appropriately explain their understanding of safeguarding and the steps they would take if they had concerns. Staff told us they refer to the online safeguarding policy accessible on the local clinical commissioning group's website.	
At our second site visit on 24 November 2022, the practice evidenced they had a new and updated safeguarding policy in place.	

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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 19 October 2022	Y
There was a fire procedure. Date of fire risk assessment: 16 Feb 2022	Y
Actions from fire risk assessment were identified and completed.	Y

Infection prevention and control

We were not assured appropriate standards of infection prevention control, cleanliness and hygiene were always being met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 21/09/2022	Partial
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Partial
Explanation of any answers and additional evidence:	

Infection prevention and waste management policies

During our first site visit on 1 November 2022, the practice was unable to locate an up-to-date infection prevention control and waste management policy, the policies they had on their system were dated 2017/2018, therefore we were not assured they reflected up to date guidance and legislation. However, all staff we interviewed were able to appropriately explain their understanding of infection prevention control, waste management and the steps they would take if they had concerns. We also saw regular infection prevention control audits were taking place. At our second site visit on 24 November 2022, the practice evidenced they had a new and updated infection prevention control and waste management policies in place.

Sharps bins

National guidance states sharps products in a clinical setting must be disposed of within appropriate sharps bins, there are three main types of sharps bins. Sharps bins with yellow lids are for the disposal of sharps excluding those contaminated with medicinal products and their residues. Sharps bins with orange lids are for the disposal of sharps including those contaminated with medicinal products and their residues. Sharps bins with a purple lid is for the disposal of sharps and clinical waste for cytotoxic and cytostatic waste. All sharps bins must be signed and dated so they can be disposed of within three months of opening. During our first site visit on 1 November 2022 we found the practice only kept yellow sharps bins on site and some of them had not been signed and dated. At our second site visit on 24 November 2022, we found all sharps bins had been signed and dated. We were also shown evidence of all three colored sharps bins being placed on order.

Cleaning logs

During our first site visit on 1 November 2022, the practice was unable to provide evidence of a cleaning log or schedule. The practice was visibly clean and we were given assurances it was being cleaned twice daily albeit not documented. At our second site visit on 24 November 2022, the practice evidenced they had a cleaning schedule and log in place, which was being signed and dated.

Risks to patients

There were some gaps in systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	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.	Partial
There were enough staff to provide appointments and prevent staff from working excessive hours	Y

Explanation of any answers and additional evidence:	
<p>During our first onsite visit on 1 November 2022, we found the reception staff were unaware of what the red-flag symptoms were for a deteriorating patient, and those potentially suffering from sepsis in the reception area.</p> <p>During our second onsite visit on 24 November 2022, we were provided with evidence confirming all reception staff had a refresher sepsis awareness training. We re-interviewed the reception staff and they were able to appropriately explain how they would identify and escalate a deteriorating patient and what the red-flag symptoms of sepsis were.</p>	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment, with the exception of administering the rotavirus vaccine.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
<p>At our first site visit on 1 November 2022, the review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients, with the sole exception of babies given the rotavirus vaccine. Rotavirus is a contagious virus that causes diarrhea, babies are usually given a live vaccine at 8 and 12 weeks. The live vaccine is generally safe, unless the baby is diagnosed as 'immunocompromised' which means they have a weak immune system and therefore may have an adverse reaction to the live vaccine. We reviewed three patient records and found the nursing team was not carrying out this check prior to administering the rotavirus vaccine. The nursing team by their own admission said they were not checking whether babies were immunocompromised, albeit they would ask in their standard questions if the baby is generally healthy and well. The nursing team gave assurances that this check would start to take place and all relevant babies would be reviewed, and if necessary recalled.</p>	

At our second site visit on 24 November 2022, the practice was able to evidence it had treated the above concern as a significant event; all nursing staff were given additional training; a new policy was put in place to ensure the necessary checks were undertaken before giving the rotavirus vaccine; and an audit was undertaken to ensure all relevant babies already given this vaccine were reviewed to ensure they were well and. The audit confirmed none of the babies had a negative reaction to the vaccine.

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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	0.75	0.58	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). (01/10/2021 to 30/09/2022) (NHSBSA)	6.5%	9.8%	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 (01/04/2022 to 30/09/2022) (NHSBSA)	5.88	5.66	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	67.3‰	61.0‰	129.6‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.34	0.56	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	5.4‰	5.9‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
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.	
During our first onsite visit on 1 November 2022, we found:	
<ul style="list-style-type: none"> - There was no up-to-date emergency drugs or equipment checklist, the checklist we saw was dated October 2022, and therefore we were not assured they had been checked since this date. - The practice did not stock emergency medicine to treat nausea/vomiting, analgesia and opiate overdose, nor did the practice have a documented risk assessment for not keeping such emergency medicines. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> - An expired Chlamydia swab. - An expired pediatric urine bag. - An expired spill kit (used to clean up spillages such as urine, blood or vomit). - We found an expired medicine box of chlorphenamine (used to treat Anaphylaxis or acute angio-oedema). - Three expired oxygen masks/airways. <p>During our second onsite visit on 24 November 2022, we found all the above concerns had been appropriately addressed and new policies, checklists, systems and procedures were put in place to prevent repetition of the same.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	4
Number of events that required action:	4

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

Event	Specific action taken
Administrative staff sent patient follow-up task list to wrong email internal email address	The practice provided the staff member with additional training, all patients were promptly followed up and apology given for the delay in actioning their case.
Incorrect vaccine administered	The patient was recalled and the correct vaccine was administered. This was reviewed by a senior GP and they concluded there was no potential or actual harm caused. Further training was provided to the clinician.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Y
Staff understood how to deal with alerts.	Y

Explanation of any answers and additional evidence:

We saw examples of actions taken on recent alerts, for example, Sodium Valproate (Epilim, Depakote and other generic brands) and carbimazole. These medicines are associated with a significant risk of birth defects and developmental disorders in children born to women who take the drugs during pregnancy. We saw confirming evidence all patients affected by this alert had a consultation and review with the lead GP discussing the risks.

Effective

Rating: Requires Improvement

We rated the practice as requires improvement for effective because the uptake for cervical screening was well below the national target of 80%, and the uptake of childhood immunisations were also well below the world health organisation target of 95%. We also found there was no documented evidence confirming nurse prescribing was being regularly monitored.

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. ¹	Y
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

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.
- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was 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

- We reviewed 40 patients across a range of long-term conditions and were satisfied they were being managed appropriately.
- 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.
- 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.
- 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.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	95	112	84.8%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	78	108	72.2%	Below 80% uptake
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)	77	108	71.3%	Below 80% uptake
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)	76	108	70.4%	Below 80% uptake
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)	91	146	62.3%	Below 80% uptake

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

Any additional evidence or comments

The practice was aware it was not meeting the world health organisation's target of 95% uptake. The practice had a re-call system, which included phone calls, text message reminders and opportunistic immunisations. The practice told us they had patients from minority communities who refused immunisation for their children due to cultural reasons. The practice catchment area also had an influx of asylum seekers in temporary accommodation. The practice told us many of the asylum seekers had small children. We were told this group of patients were hard to reach and many moved to addresses without informing the practice. The practice provided assurances it would put in place an action plan to improve the uptake of childhood immunisations.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	57.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	55.9%	47.7%	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)	53.7%	57.2%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	43.5%	55.6%	54.9%	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
<p>The practice was aware it was not meeting national uptake target of 80%. The practice explained it had patients from minority communities who refused cervical screening due to cultural reasons. The practice catchment area also had an influx of asylum seekers in temporary accommodation. Many of the asylum seekers were women eligible for cervical screening. We were told this group of patients were hard to reach, and again many moved address without informing the practice. The practice provided assurances it would put in place an action plan to improve the uptake of cervical screening.</p> <p>The practice also showed us unverified and unpublished data extracted from their internal database and QOF system. The cervical screening indicator used by the CQC to measure the cervical screening indicator comes from the UK Health and Security Agency definition, and not the QOF definition. Therefore, we are not able to make a direct statistical comparison. In addition, the CQC can only rely on data that has been published and verified by the governing agency in this case the UK Health and Security Agency.</p>

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

<p><u>Two-week wait cancer referral</u></p> <p>A 'two week wait' (TWW) referral is a request from a GP to ask the hospital for an urgent appointment for a patient, because the patient has symptoms that might indicate a cancer diagnosis. The practice carried out an audit to assess how effective their system was in successfully referring potential cancer patients at the earliest opportunity.</p> <p>The first audit was carried out in 2021 and a total of 99 patients were identified out of which 35 patients had a potential delay and/or issue with their referral. The second audit was carried out in 2022 and a total of 114 patients were identified. All patients had been referred appropriately.</p> <p><u>Hand hygiene</u></p> <p>In response to the pandemic the practice had been carrying out annual hand hygiene audit, this entailed a senior clinician observing staff to ensure staff were:</p> <ul style="list-style-type: none"> • Cleaning their hands at the appropriate intervals • Using the correct technique • Covering up any cuts • Bare below the elbows • and whether paper towels were being disposed of without touching the bin. <p>Two audits had been carried out, the first in 2021 and second in 2022, both audits showed 100% achievement for all staff.</p>
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Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y

There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice employed a nurse prescriber. National guidelines state nurse prescribers should be regularly monitored to ensure their prescribing competency, this should include regular 1:1's and review of their consultations, prescribing and treatment plans for patients. Senior staff confirmed these were taking place, however, there was no documented evidence of this. After the inspection, the practice was able to provide confirming evidence that these reviews were now being documented.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

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 Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y

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 interviews	We interviewed 32 patients and they all commented that staff provided a helpful and friendly service and treated them with compassion, respect and kindness.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	73.1%	83.5%	84.7%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	74.0%	81.1%	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)	80.1%	91.6%	93.1%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to	59.0%	70.2%	72.4%	No statistical variation

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

Any additional evidence or comments
<p><u>GP Patient Survey</u></p> <p>The practice was aware of the lower than average scores for questions relating to the caring domain (as shown immediately above). We interviewed 32 patients and all the patients responded positively to all four of the GP patient survey questions outlined in the table immediately above.</p>

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

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment / patients were not 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 average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	77.6%	88.1%	89.9%	Tending towards variation (negative)

Source	Feedback
Interviews with patients.	All 32 patients told us they felt supported and were involved in decisions about care and treatment.

	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.	172 carers which is 1% of the patient list.
How the practice supported carers (including young carers).	Carers were offered longer appointments, free influenza vaccines, and were signposted to local support groups.
How the practice supported recently bereaved patients.	Following a bereavement, the doctor phoned the family to offer their condolences and would signpost them to local 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: Requires Improvement

We rated responsive as requires improvement because the GP patient survey data and patients we interviewed showed dissatisfaction with telephone access and the types of appointments offered.

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 - 6.30pm
Tuesday	8am - 6.30pm
Wednesday	8am - 6.30pm
Thursday	8am - 6.30pm
Friday	8am - 6.30pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none">• 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 three local extended hours hubs commissioned by Integrated Care Board. Appointments could be booked every weekday between 6.30pm and 8pm and every Saturday 9am to 5pm.
- The practice held a register of patients living in vulnerable circumstances including asylum seekers, 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 not always able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Partial
Patients were able to make appointments in a way which met their needs	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	32.6%	N/A	52.7%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	42.8%	54.5%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	48.5%	55.0%	55.2%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
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)	57.1%	68.6%	71.9%	Tending towards variation (negative)

Any additional evidence or comments

The practice was aware it scored below local and national averages in the GP patient survey for the four indicators directly above. We spoke to 32 patients all of whom also confirmed they were dissatisfied with access to the practice, most particularly patients complained about prolonged telephone waiting times, and not being able to see a GP face to face without first having a telephone consultation.

The practice told us it was investing in more staff and a new advanced telephony system. They explained they had a telephone triage policy for all doctor's appointments and following discussion with the doctor a face to face consultation may be booked, if the clinician felt it was appropriate, which was often on the same day or at a mutually convenient time. It was the practice's view that this policy allowed them to deal with a larger number of patients in a more time efficient manner. The practice also confirmed face to face appointments could be directly booked with the nursing team, pharmacists, phlebotomists, and physiotherapist.

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.	18
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint regarding poor customer service from reception staff.	Investigated by management, apology given and staff provided with further customer service training.
Complaint regarding prolonged call waiting time on the telephone	Investigated by management and they concluded there was an issue with the telephone lines that day, action plan made for a new telephone line to be installed, apology given to patient.

Well-led

Rating: Requires Improvement

We rated the practice requires improvement for well-led because we were not assured there were appropriate governance, systems and processes in place to ensure: safe infection prevention control measures were in place; emergency equipment and medicines remained in date and safe to use; policies were reviewed to ensure they remained up to date and relevant; documented supervision of the nurse prescriber; and the safe administration of the rotavirus vaccine.

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

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Culture

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

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

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

Source	Feedback
Staff interviews	We spoke with several members of staff during the inspection. All stated they felt well supported and that they had access to the equipment, tools and training necessary to enable them to perform their roles well. We were told staff were given protected time to enable them to undertake training and carry out non-clinical duties. Staff reported there were good, effective working relationships between managers and staff and clinical and non-clinical staff. Staff told us if they had any concerns they would raise them with management, with the confidence their concerns would be taken seriously and acted upon.

Governance arrangements

There was not always 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.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
As explained above (see safe section) we were not assured there was a good governance, management and systems in place to mitigate risk, because we found:	

- Out of date policies and procedures.
- Out of date emergency medicines and equipment.
- Sharps bins were not signed and dated, the practice did not stock all the necessary sharps bins required in a clinical setting.
- No documented cleaning schedules and logs.
- No documented risk assessment for not stocking emergency medicine to treat nausea/vomiting, analgesia and opiate overdose.
- No documented supervision of the nurse's prescribing.

The provider responded to the concerns identified during our first visit and made improvements which need to be embedded so risks are identified and mitigated.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	
Explanation of any answers and additional evidence:	
As explained in the safe section, we were not assured there was safe system in place for the administration of the rotavirus vaccine, and reception staff were unable to demonstrate an understanding of sepsis awareness.	

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
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Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Continuous improvement and innovation

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

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

Examples of continuous learning and improvement

The practice evidenced it had an extensive audit programme which showed several clinical and non-clinical audits are undertaken on an annual basis, all of which showed improvement.

The practice was responsive to all the concerns identified at this inspection and provided evidence of corrective actions to address them.

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.