

## Inspection Evidence Table

The Sandhurst Group Practice

(1-542751085)

**Inspection Date: 2 May 2023**

Date of data download: 16/05/2023

## Overall rating: Good

At our inspection in July 2022, we identified risks to patients which led to the Care Quality Commission (CQC) taking enforcement action and rating the practice as inadequate. The reason for that rating was because:

- The practice was not able to demonstrate they delivered safe and effective care to all patients.
- Systems and processes in place did not ensure good governance to protect patients from the risk of harm.
- The practice had not ensured there were enough suitably qualified, competent and skilled staff to meet people's care and treatment needs.

We followed up the highest risks identified in our enforcement action in November 2022 and found improvements had been made. We did not rate the practice at that inspection.

At this inspection we found:

- The practice was able to demonstrate that care and treatment was safe and effective for patients.
- The practice had ensured that staff working at the practice were suitably qualified and competent to meet patient care and treatment needs.
- The practice had responded to patient feedback and performance data to identify improvements and design a service which met the needs of its patients.
- Systems and processes to ensure good governance and protect patients from the risk of harm had been developed and operated consistently.

## Safe

## Rating: Good

At our inspection in July 2022, we rated the practice as inadequate for the provision of safe services because:

- There were not clear systems, policies and processes to keep people safe and safeguarded from abuse.
- Staff who acted as chaperones had not received appropriate training or Disclosure and Barring Service (DBS) checks to carry out the role.
- Recruitment gaps meant there were not always enough staff to provide appointments and staff worked excessive hours.
- We found a backlog of clinical correspondence awaiting review and new patients notes requiring summarising.
- Nurses were not always appropriately authorised to administer medicines under Patient Group Directions (PGDs).
- The practice did not always ensure medicines were prescribed safely to all patients or review their care appropriately.

- There was not an effective system to learn and make improvements when things went wrong.

At this inspection in April 2023, we rated the key question of safe services as good because:

- Staff had completed safeguarding training to the level indicated in national intercollegiate guidance. The practice had reviewed their safeguarding policy and processes and audited the clinical system to ensure patient records contained accurate information.
- Staff who acted as chaperones were appropriately trained and had received DBS checks.
- Staffing levels had been reviewed to avoid staff working excessive hours. The practice had oversight of vacancies and gaps in clinical rotas and had systems to respond and manage this.
- Backlogs of clinical correspondence had been cleared and management had effective oversight to ensure new systems and processes operated effectively.
- Nurses were appropriately authorised to administer medicines under PGDs.
- Patients received annual reviews and monitoring tests for conditions and medications to ensure medicines were prescribed safely.
- There was an effective system to record, make improvements and learn when things went wrong.
- There was a system to receive and respond to patient safety alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA), however it was not always effective.
- A system to ensure prescription stationary was tracked and monitored throughout the practice existed but had not operated as intended.

### 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 comprehensive inspection in July 2022, we found systems and processes related to safeguarding were not always effective. For example, we were not assured that the coding of safeguarding referrals and the adults and children's safeguarding registers were accurate and up to date. We also found safeguarding training had not been completed by all staff in line with the practice policy or national guidance	

because 7 members of nursing staff had not completed training to the level required by the practice and national guidance and 2 members of staff that acted as chaperones had not completed any safeguarding training. We also found 3 members of staff that acted as chaperones did not have appropriate Disclosure and Barring Service (DBS) checks in place and 2 of these staff had acted as chaperones prior to the inspection.

At our focused inspection in November 2022, we found the practice had reviewed all the safeguarding referrals, and requests for information from partner organisations over the last 2 years and, the adult's and children's safeguarding registers. This review ensured all patients were coded correctly according to the practices' safeguarding policy. An audit had been completed following this review which demonstrated full compliance.

We also found the 7 nurses had completed safeguarding training to the standard required in the practice policy and national guidance and the member of staff without training at the last inspection had provided a certificate to evidence completed training. The practice had decided that only clinical staff with up-to-date safeguarding training would act as chaperones while other staff completed their training.

At this inspection in April 2023, we found all staff were up to date with safeguarding training to the level specified in the practice training policy which followed national guidance. We found the practice had scheduled meetings to discuss safeguarding concerns and referrals which was attended by partner organisations. All staff received a DBS check appropriate for their role and the practice policy was that chaperones had an enhanced check. We also found staff could access a list of trained chaperones and management had oversight of staff still needing to complete the training.

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.	P

Explanation of any answers and additional evidence:

At our inspection in July 2022 we reviewed 6 staff files and found 2 members of staff did not have appropriate DBS checks in place. All other recruitment files were completed in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection in April 2023, we reviewed 3 staff files and found all had records of completed DBS checks. We also found all other recruitment checks were completed in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also checked the practices' policy and process for checking members of staff immunity to communicable diseases and the practice explained they followed national guidance. However, the management had found they did not have records of staffs' immunity status. They explained the practice had a system and process to collect and record this information, but an internal review had identified the records were not available. In response, a risk assessment had been completed to determine the risk to staff and patients and this categorised the risk as low. All staff had been requested to provide evidence of immunity again and where they did not have evidence, to have a blood test. To speed up the process the GP partners had agreed the practice would complete the blood tests for staff and if the results indicated someone was not immune to a disease in line with national guidance, they would be offered a booster vaccination. If they declined, a risk assessment would be completed to determine which duties they could perform safely. The management team were monitoring the progress of the blood tests and had a target completion date of 31 May 2023.

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: Yorktown Road Surgery 21 September 2022 Owlsmoor Surgery 27 September 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: 21 September 2022 (both sites)	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022, we found that health and safety systems and processes were not effective because although an audit had taken place, the practice was not able to provide evidence that the actions from the previous audit had been completed. This meant the practice was unable to provide assurance that health and safety was maintained in line with national standards.</p> <p>We found the previous fire risk assessment did not provide complete assurance that all fire risks had been identified and appropriate safety measures had been put in place to mitigate risks to patients and staff at both sites. For example, the risk assessment was not site specific and, sources of ignition and details of stored oxygen cylinders were not included. The practice could not demonstrate the competence of the person who completed the fire risk assessment.</p> <p>At our focused inspection in November 2022, we found health and safety and fire risk assessments had been completed for both premises by an external contractor in September 2022. These risks assessments contained action plans for remedial work to improve the safety of the premises. The practice had prioritised the highest risks and had completed some of the actions, but others were in progress with due dates for completion. Management had oversight and monitored progress against the action plan. We sampled items marked as in progress and complete on the practice's action plan and found it was accurately recorded.</p> <p>At this inspection in April 2023, we found all actions except 2 in the health and safety risk assessment had been completed and the practice explained why these were not completed. One of the actions was to create risk assessments for staff that drove for work purposes. However, the practice had considered this and felt it was not relevant to their practice because home visits were provided by staff from the local urgent care team not the practice, so staff did not have a reason to drive for work. The other action was to have damage to the roof at the Yorktown Road site fixed to prevent injuries from falling roof materials. The practice provided assurance the roof had been assessed by an external contractor who confirmed the roof was safe and did not need immediate repair to protect staff and the public and the practice was finding out what repair work, if any, was needed.</p> <p>At this inspection in April 2023, we found a fire drill had been completed on 30 January 2023 and there was a weekly check of the fire alarm system and fire extinguishers. We sampled the logs that recorded checks and found this process was being followed. We also found there was a daily huddle meeting where the duty fire marshals were announced.</p>	

We found the practice had an agreement with an external contractor for monthly testing of the water supply to check for the presence of Legionella and weekly flushing of rarely used water outlets was carried out by staff. (Legionella is a particular bacterium which can contaminate water systems in buildings). We saw evidence the weekly flushing was carried out and the external contractor tested the water on 21 April 2023. Legionella was not detected.

There was a programme for portable appliance testing and calibration of medical equipment. This had been completed in May 2022 and all appliances had passed except 3. The practice showed evidence these items had been destroyed and confirmed repeat annual testing was booked.

**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:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022 the practice training record evidenced that clinical and non-clinical staff had not completed or were not up to date with infection prevention and control (IPC) training. We also found the IPC audit had been combined with the health and safety audit, but this did not accurately reflect the infection control issues for either site. We were not assured that the practice had oversight of IPC risks or that actions to reduce, remove or mitigate risks were being completed in a timely manner because the practice did provide evidence to assure us that actions from previous audits had been completed.</p> <p>At our focused inspection in November 2022 we found the practice had an agreement with an external company to carry out IPC audits with the practice, to provide specialist training for the IPC lead and to provide ongoing support and guidance to the practice. An audit had been completed on 29 September 2022 and an action plan to reduce the risks had been created. At the time of the inspection, not all the actions were completed but we were assured the practice had oversight of this action plan and had set dates for completion and full compliance. We sampled some of the completed actions and found they were accurately recorded as per the action plan.</p> <p>At this inspection in April 2023, we found all staff had completed IPC training and the IPC lead had completed specialist training for their role. We also found full compliance with the action plans from the September 2022 audits of both sites had been achieved. We sampled the action plans and found fridges used to store vaccines had clear signage to remind people not to unplug them, the cleaner’s cupboard was well organised, records of cleaning were kept, and surfaces were clean and clear of clutter.</p>	

## Risks to patients

**There were adequate systems to assess, monitor and manage risks to patient safety.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	P
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022, we found staffing levels were recorded as the highest risk on the practice risk register. At the time of that inspection, we found a salaried GP had just left the practice and 4 further GPs had submitted resignations. The practice had adapted the appointment system to make use of more on the day appointments and continued to use locum GPs, but the rotas indicated gaps in GP coverage across both sites until December 2022. We also found the practice was not able to provide a clear overview of the number of vacancies for both clinical and non-clinical roles.</p> <p>We found that staff worked additional hours to try and reduce backlogs of work, however, despite this there was a backlog of clinical correspondence.</p> <p>We also reviewed the mandatory training list and found clinical and non-clinical staff had either not completed sepsis awareness training or had not completed it in the last year which was not in line with the practice training policy. We were told staff had access to guidance about how to identify the signs of sepsis and staff we spoke with were aware of the actions to take if they identified an acutely unwell patient.</p> <p>At this inspection in April 2023, we found staffing levels continued to be a challenge for the practice and recruitment had not been as successful as the practice had hoped. However, the clinical staff team consisted of:</p> <ul style="list-style-type: none"> <li>• 3 GP partners</li> <li>• 2 associate GP partners</li> <li>• 1 salaried GP</li> <li>• 1 Nurse Manager</li> <li>• 3 Practice Nurses</li> <li>• 2 Nurse Associates</li> <li>• 1 Healthcare Assistant (HCA)</li> <li>• 2 Phlebotomists</li> <li>• 1 Nurse apprentice in training</li> </ul> <p>We found evidence that the practice had completed an audit of patient access which had helped identify the required staffing levels across all teams. This audit gave the management clear oversight of the vacancies. At the time of the inspection, staffing recruitment campaigns for the following vacancies were ongoing:</p>	

- 3 part-time receptionists
- 1 Practice nurse
- 1 HCA

The practice had agreements with locum agencies to help meet the demand for appointments from patients and to prevent staff from working excessive hours when there were staffing shortages. There were planned minimum staffing levels to ensure there was sufficient staff on duty to meet patient demand and to accommodate both planned and unplanned staff absences. Reception supervisors monitored staffing levels and booked locum GPs where required.

We found an induction process had been introduced for staff joining the practice and this ensured staff had the information and access to systems they needed to perform their roles.

We also found all staff had completed sepsis training except for 5 new members of staff. These members of staff had recently joined the practice and were in the early stages of their induction process. This risk had been assessed and control measures to reduce or mitigate it were in place. These included the fact these staff were always supervised while completing their induction and mandatory training, which included sepsis awareness. We also saw guidance tools in clinical rooms to assist clinicians in decision making when presented with symptoms which may indicate sepsis.

### 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:            At our inspection in July 2022, we found there was a backlog of 213 new patient notes waiting to be summarised and this risk had not been identified by the practice. We also found the practice did not have a system or process to monitor delays in urgent two-week wait (2WW) referrals and the responsibility to notify the practice of a delay belonged to the patient. (A two-week wait referral is for patients suspected of having symptoms which might indicate they have cancer and is designed to ensure diagnosis and treatment is achieved as quickly as possible). We also found there was a backlog of 500 items of clinical correspondence which had been actioned but had not been processed by the workflow team and 774 documents were awaiting review.</p>	

At our focused inspection in November 2022, we inspected the highest risks and found improvements had been made to the 2WW referral system. The practice had trained more staff to make referrals and there was a clear protocol for how to make a referral which would be accepted and not rejected by secondary care. Audits were run on a 2-week basis to ensure no referrals had been delayed, missed or rejected and the responsibility for monitoring referrals belonged to the practice not the patient.

At this inspection in April 2023, we checked this process had continued and was embedded and found evidence that it was operating as the practice intended.

We also checked the clinical inboxes during the remote clinical searches and found there were no backlogs of clinical correspondence. Our GP specialist advisor completed remote clinical searches which found the practice was processing correspondence. We were told the practice had previously outsourced the management of clinical correspondence to their Primary Care Network (PCN) however, the practice had found this process had not operated as they expected, and they had terminated the contract. Overtime payments and the recruitment of additional staff had been used to clear backlogs. The practice had filled the vacancies required to allow the practice to manage this process themselves either via internal moves or recruitment. For example, we found the practice had recruited a medical secretary with previous experience and had created a new role in the team. The new member of staff was being trained at the time of the inspection and there was 1 vacancy remaining.

### Appropriate and safe use of medicines

#### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation.

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.89	0.79	0.86	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). (01/01/2022 to 31/12/2022) (NHSBSA)	9.8%	8.5%	8.1%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) (NHSBSA)	6.01	5.33	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	72.7‰	73.5‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related	0.43	0.55	0.56	No statistical variation



Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	4.2‰	5.5‰	6.8‰	Tending towards variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	P
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.	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.	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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	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
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>At our inspection in July 2022, we found staff did not have the appropriate authorisations to administer medicines. We also found the practice was not able to demonstrate there was a process in place to ensure the</p>	

competency of non-medical prescribers (NMPs). Our remote clinical searches identified patients prescribed high risk medicines and with long-term conditions, specifically diabetic retinopathy and hypothyroidism had not had medication reviews in the last 12 months. The practice was aware they were behind on medication reviews but had not added this to the risk register and did not have a plan to improve their completion of medication reviews.

At our focused inspection in November 2022, we focused on the areas of highest risk and did not complete remote clinical searches of the issues identified above. We reviewed the practices' process to ensure the competency of NMPs and found there was a clinical supervision policy which clearly documented who was responsible for staff members and the supervision requirements. These included dedicated time for clinical supervision meetings and the frequency of prescribing audits to ensure NMPs were working within their competencies. We found 2 audits of prescribing had been completed, with areas for improvement identified and these had been completed by the second audit.

At this inspection we found the system to manage prescription stationary was not operating as the practice had intended because documentation did not contain accurate information to allow the practice to track and monitor prescription stationary when in use in the practice. The practice immediately audited the process, identified the cause, and took the remedial action to fix the process. A significant event was recorded, and new process was shared with the practice team along with the learning about what had gone wrong.

At this inspection in April 2023, we found the clinical supervision process for NMPs had continued and was operating as the practice intended. For example, 2 further audits of the NMPs prescribing had been completed since our last inspection and staff were clear about who they should approach if they needed advice outside of clinical supervision meetings.

Our GP specialist advisor completed remote clinical searches and reviewed the clinical records of patients taking high risk medicines. We found 55 patients had been prescribed a potassium sparing diuretic and 9 of these patients had not received the required monitoring to ensure it is safe to continue prescribing the medicine. (This medicine is used to increase the amount of fluid passed from the body during urination while preventing too much potassium being lost). Our GP specialist advisor reviewed the clinical records of 5 patients and found all were overdue monitoring, however, 3 of the patients had been sent recall reminders for monitoring tests before the most recent prescription was issued and 2 had been recalled afterwards. 3 of the patients did not have the underlying condition for the medicine recorded in their clinical record which is best practice. However, these results demonstrated the practice had a recall system and a process to identify overdue patients.

**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: 47	Y
Number of events that required action: 47	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022 we found the system to record and report significant events was not effective because staff were not clear about when to raise a significant event and we found examples where significant events could have been raised but had not been. We also found that learning from significant events that had been raised was not routinely discussed or shared within the practice to prevent incident reoccurring.</p> <p>At our focused inspection in November 2022, we followed this up and found improvements. The practice had reviewed its policy for significant events and amended it in line with national guidance, there was a new system for recording significant events and an audit had been added to the annual audit programme. We also found staff were more confident to raise these incidents and learning was shared.</p> <p>At this inspection in April 2023, we found this process was embedded and operating as the practice intended. Staff told us how they viewed significant events as opportunities to learn and improve and that they did not fear any repercussions if they raised a significant event. For example, whilst onsite our spot check identified the practices' system to manage prescription stationary was not operating as the practice intended. The member of staff responsible immediately completed an audit and raised a significant event so necessary remedial action could be taken, staff could be made aware and learning to prevent it happening again could be shared.</p>	

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

Event	Specific action taken
Patient had consultation with a clinician that required referral, but this was not completed by the practice in a timely manner.	A patient notified the practice they were still waiting for several appointments after being told they were being referred to other services. The practice investigated the concerns and found no harm had been caused. The investigation found that the task to instruct the medical secretaries had not been completed correctly for 1 referral. For another, the patient had been referred by the practice to a specialist team, however the referral was not accepted because that team did not provide the required treatment so another referral to the correct specialist was required. All referrals were completed for

	the patient. The issue was scheduled for a clinical meeting, so all clinicians were clear about the practices' processes to raise a referral.
--	---

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>In July 2022, we found 39 patients taking 2 medicines in combination, Clopidogrel and Omeprazole, despite a patient safety alert in 2014 advising against such a combination. We were not assured there was an effective system to ensure medicines safety alerts were logged and acted upon appropriately.</p> <p>At our focused inspection in November 2022, we found improvements had been made and there was a named lead to receive medicines safety alerts and a clear process for action to be taken in response to alerts. A member of CQC's Medicines Optimisation Team repeated the same search for Clopidogrel and Omeprazole being taken in combination and no patients were identified as taking these medicines together.</p> <p>At this inspection in April 2023, our GP specialist advisor found 3 patients taking more than 20 milligrams of Citalopram and who were over 65 years of age. Citalopram is used to treat depression and can increase the QT interval which can lead to a potentially fatal ventricular arrhythmia and this risk increases with age. (The QT interval is the time it takes for the ventricles of the heart to contract and relax). A medicines safety alert from 2014 advised of the risk for patients over 65 years old taking more than 20 milligrams of this medicine. Our GP specialist advisor reviewed the patient records and found 1 patient had been prescribed this medicine after their most recent medicine review and had not been told of the risks and 1 patient had started taking this medicine recently and had not been informed of the risk. However, the third patient had only just become 65 years old. The practice confirmed they would review all 3 patient records and advise the patients of the risk of taking this medicine or see if an alternative medicine would be better for the patient.</p>	

## Effective

## Rating: Good

At our inspection in July 2022, we rated the key question of providing effective services as requires improvement because:

- The practice systems and processes for acting on medicine safety alerts had not ensured prescribing was monitored effectively or in line with guidance.
- Patients with long term conditions did not always receive care and treatment in line with national guidance.
- We found limited evidence that the practice monitored the outcomes of care and treatment.
- There was a lack of oversight of training and there were significant gaps in training compliance for both clinical and non-clinical staff.
- Some staff had not received inductions when they started employment, and many had not received appraisals in the last 12 months.
- The practice could not demonstrate how they were assured of the competence of staff employed in advanced clinical practice.
- The system to manage incoming information about patients when they received care and treatment from other services was not effective.
- Staff were not always proactive or consistent in helping patients to live healthier lives.

At our focused inspection in November 2022, we followed up the highest priority risks included in our enforcement action and found improvements had been made to the quality of care and documentation of care plans within clinical records, but we did not rate this key question.

At this inspection in April 2023, we have rated the key question of effective services as good because:

- The practice had new policies, systems and processes to receive and act on information from medicine safety alerts. However, these had not operated as effectively or consistently as the practice had intended.
- Patients with long term conditions received annual condition and medicine reviews in line with recommended national guidance, however these did not always follow a structured format to document the content of the review.
- Patients with a potential diagnosis of diabetes were not always coded with diagnosis or told of their diagnosis.
- The practice had clear oversight of staff compliance with mandatory training required by the practice and staff were up to date with training.
- Staff who had joined the practice had received inductions and the practice was up to date with staff appraisals.
- Staff responsible for the supervision of staff employed in advanced clinical practice had dedicated time for supervision and we found supervision meetings took place and their prescribing was audited.
- There was a system to monitor and manage incoming information about patients care and treatment from other services and we found this operating effectively as there were no backlog of clinical correspondence awaiting processing. Quality improvement activity was used to ensure medicines were prescribed safely to patients

*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. <sup>2</sup>	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	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
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022, we found the practice was not able to demonstrate that the systems and processes to keep staff up to date with evidence-based practice were effective because the process for acting on medicine safety alerts had not ensured prescribing was monitored effectively in line with guidance. We also found that there was a lack of consistency of where mental health care plans were recorded in the patient record and of the 6 care plans we reviewed, we found 4 of the patients did not have an up to date mental health care plan.</p> <p>At our focused inspection in November 2022, a member of the CQC Medicines Optimisation Team completed remote clinical searches and found 52 patients were eligible for mental health care plans. They reviewed 5 patient records at random and found no concerns with the way care plans were recorded for those patients.</p> <p>At this inspection in April 2023, our GP specialist advisor reviewed the mental health register in the clinical system and found 63 patients were eligible for a mental health care plan. Of these patients 60 (95%) were recorded as having a care plan completed with records demonstrating that monitoring of the patients' care had also been completed.</p> <p>At this inspection we found there was a process for receiving and acting on medicines safety alerts. The practice prescribing policy had a process for categorising safety alerts as either high, medium or low risk with each category having specific actions required by prescribing lead. However, although there was a system to receive and act upon medicines safety alerts, we found it had not operated effectively for every alert. Our remote clinical searches found 2 examples where prescribing had continued contrary to the advice in a safety alerts. For the example where 2 patients over 65 years of age had been prescribed more than 20 milligrams of Citalopram, we were unable to find evidence that 1 patient had been informed of the risks of taking this</p>	

medicine and for the other this had only happened recently. For the patients with asthma that had not been issued emergency steroid cards, the practice confirmed they would immediately review those patients and issue them where appropriate. However, we were not assured that this new process was completely embedded and operating as effectively as intended.

## Effective care for the practice population

### Findings

We found:

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.
- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- All patients with a learning disability were offered an annual health check. During our remote clinical searches, we checked the clinical system and found 39 patients on the learning disability register of which 30 (78%) had a care plan completed.
- 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 an end of life register and took part in a regular multi-disciplinary team (MDT) meeting with the hospice and district nursing team to discuss the care needs for those patients.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illnesses.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

Our remote clinical searches identified 666 patients with a diagnosis of hypothyroidism, of which 9 patients had not received routine monitoring within the required timescales (hypothyroidism is a condition which means the thyroid gland is underactive and does not produce enough hormones). These monitoring tests check whether the amount of hormones produced by the thyroid are within the normal range and determine how it should be treated. Our GP specialist advisor reviewed 3 of these patients' clinical records and found the prescriber had identified the patients were overdue monitoring and the patients had been recalled for monitoring tests but had not responded. All 3 patients had been coded as having received medicines reviews, however, our GP specialist advisor found these reviews had not followed a structured format to record what had been checked at the review.

There were 68 patients with diabetic retinopathy who had a HbA1c result greater than 74mmol/l at their last monitoring appointment (HbA1c is the average blood glucose (sugar) levels for the last 2-3 months and is used to give an indication of how well controlled a patient's diabetes is. Diabetic retinopathy is damage to the retina which, if not treated, can lead to loss of sight). We reviewed 3 of these records and found all had received medicines reviews since their last test results and in the last 3 months. We also found 2 of the 3 patients had a diabetic annual review (DAR) of their condition in the last 12 months and the other patient had their condition reviewed partially but had not had a complete DAR.

We found 86 patients with a diagnosis of asthma who had had been prescribed 2 or more courses of rescue steroids in the preceding 12 months. Our GP specialist advisor reviewed 3 patient records and all 3 had received structured asthma reviews in line with current national guidance. However, all 3 patients required emergency steroid cards and we did not find evidence these had been issued to them. We identified these patients to the practice who confirmed they would review the patients records and issue the emergency steroid cards to them.

There were 52 patients coded with chronic kidney disease stages 4 or 5. Of these, 7 were indicated by our remote clinical searches as overdue their routine urea and electrolyte (U&E) monitoring in the last nine months. This test is used to check whether the electrolyte levels in the body are too high or too low as this can cause abnormal heart rhythms. However, our GP specialist advisor reviewed the records of 3 of these patients and found they were being cared for by secondary care. We discussed the practice process for checking test results taken in other healthcare settings and the practice explained there had been a problem accessing and downloading monitoring tests results from the secondary care system into the practices own system. However, we found evidence these results had been checked by the practice.

Our remote clinical searches identified 34 patients with a potential missed diagnosis of diabetes. Our GP specialist advisor reviewed 5 records and found 4 of the 5 patients were diabetic based on the results of the diagnostic tests in the clinical system. 1 required further tests to confirm the diagnosis. Of these 4 patients, 3 had not been coded as diabetic which posed the risk that they would not be referred to national diabetes prevention programmes or be recalled for monitoring of their condition. All 4 patients had also not been told of their diagnosis.

We also found:

- Patients with long term conditions were offered an annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.



- 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%
--------------------	-----------	-------------	----------	---------------------------------

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
<p>At the time of the inspection in April 2023, CQC did not have validated data for the practice's achievement regarding childhood immunisations. This was discussed with the local Integrated Care Board (ICB) who provided data the practice had submitted to them. Although this data has not been verified and is not a like for like comparison of the data we include in inspection reports, the data showed in April 2023:</p> <ul style="list-style-type: none"> <li>• The overall uptake rate of childhood immunisations at the practice was 91.8%</li> <li>• The overall uptake rate for preschool aged children was 90.2%</li> <li>• The overall uptake rate of primary school aged children was 97.2%</li> <li>• The overall uptake rate for booster doses of childhood vaccinations was 94.3%</li> </ul> <p>We are unable to comment on the achievements shown in the data submitted by the ICB but have included it to demonstrate the practice has an ongoing programme to offer immunisation to eligible children under the recommended national schedule of vaccination.</p>

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	77.7%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	74.6%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (31/12/2022 to 31/12/2022) (UKHSA)	75.6%	N/A	80.0%	Below 80% target
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)	42.3%	50.1%	54.9%	No statistical variation

### Any additional evidence or comments

At our inspection in July 2022 we recommended the practice continued their work to improve the uptake of screening and immunisations. The practice had achieved 75.5% which was below the national target of 80%.

At this inspection in April 2023, our data showed uptake was 75.6%, however, the practice still had not achieved the 80% target. We discussed cervical screening uptake with the practice who provided their unpublished, unverified data for cervical screening uptake as of 30 March 2023. This did not provide a direct comparison because the practice's data was from the Quality and Outcomes Framework (QoF), but the practice's figures showed 75% of women aged between 25 and 49 years and 80% of women aged between 50 and 64 years had an adequate cervical screening appointment.

### Monitoring care and treatment

**The practice used quality improvement activity to review the effectiveness and appropriateness of the care provided.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past 2 years:</p> <p>At our inspection in July 2022, we found limited evidence of quality improvement activity. The practice shared single-cycle audits with us and explained that clinical audits had been paused during the COVID-19 pandemic and were just being restarted at the time of that inspection.</p> <p>At our focused inspection in November 2022, we followed up the highest risks included in our enforcement action and did not review evidence related to quality improvement activity.</p> <p>At this inspection in April 2023, we found quality improvement activity had increased and was used to monitor and improve the quality of care for patients. For example, we were provided evidence of a 3-cycle audit of patients prescribed high risk medicines called Direct Acting Oral Anticoagulant (DOACs). These medicines require ongoing monitoring every 12 months and at our inspection in July 2022 we found patients who were overdue their monitoring. The practice designed an audit with a target that 95% of patients would have their creatine clearance (CrCL) calculation recorded. This calculation is used to establish the correct dose of medicine.</p> <p>Two searches were created to identify the highest risk patients which were those that had never had their CrCL recorded and, another search to identify those patients that were overdue testing. The results of the first cycle of searches identified:</p> <ul style="list-style-type: none"> <li>• 385 patients had been prescribed a DOAC.</li> <li>• 64 had never had their CrCL recorded.</li> </ul>	

- 116 had not had a CrCL recorded in the last 12 months.

The clinical records were reviewed and of the 64 patients that had never had a CrCL recorded, the practice found 57 patients had blood test results which had been reviewed but the CrCL calculation had not been completed. Similarly, of the 116 that had not had their CrCL recorded in the last 12 months, 107 patients had their blood test results but not a completed calculation.

For those patients that had results but no calculation, they were assessed, the calculation was completed, and their dose was checked. The patients that needed a blood test were invited for testing.

A second cycle was repeated a week later, and the results were:

- 4 patients still did not have a CrCL recorded.
- 20 remained as not having a CrCL done in the previous year.
- 2 patients needed a dosage adjustment.

The audit was repeated in March 2023 and identified 16 patients as not having a CrCL recorded in the last 12 months. The practice reviewed these patients and found:

- 9 patients had had their blood tested and their CrCL was calculated but no changes to their dosage were needed.
- 2 patients had blood tests booked.
- 2 patients been recalled for blood tests but not booked their tests.
- 1 patient had 3 unsuccessful blood tests but had another appointment booked.
- 1 patient had started the medicine very recently and their blood results were stored on another system. These were inputted into the practices' clinical system.
- 1 patient had their CrCL calculated but still appeared on search list.

The audit did not include whether the 95% target for CrCL calculation had been achieved but stated a significant improvement had been made between the first and third cycles of the audit.

We were also shown evidence of a 2-cycle audit of patients taking Amiodarone which is a medicine used to treat or prevent heart rhythm disorders and requires ongoing monitoring every six months. In the first cycle in October 2022, 8 patients were found to be overdue their routine monitoring tests to ensure it was safe to continue prescribing the medicine. All 8 were contacted and had blood tests arranged. To identify overdue patients the practice used a search of the clinical system to alert them to patients who were due monitoring tests. The audit was repeated in February 2023 and no patients were overdue monitoring. The audit is scheduled to be repeated in July 2023.

## 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
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022, we found the practice was not able to demonstrate the competence of non-medical prescribers to ensure they were prescribing safely. We found the practice had a mandatory training policy in place, however, there was a lack of oversight of training compliance, and we found gaps in training records for both clinical and non-clinical staff. Staff were entitled to protected time for learning and development but due to staffing shortages and backlogs of work this could be cancelled and used to cover gaps in rotas or to help address backlogs. We also found inductions and appraisals had not been completed for staff employed and the practice was not able to demonstrate how they were assured of the competence of staff employed in advanced clinical practice.</p> <p>At our focused inspection in November 2022, we followed up the highest risks and found the practice had improved oversight and governance of non-medical prescribers and staff working in advanced clinical practice. These changes included a clinical supervision policy which included staff who worked at the practice but were not employees, for example, PCN pharmacists. Changes also included scheduled time for clinical supervision meetings and a programme of audits to ensure staff in these roles were working within their competence. At this inspection in April 2023, we found these processes had continued to operate as we found them when we inspected in November 2022.</p> <p>At this inspection in April 2023, we found there was an induction programme which included an information pack for new staff and a checklist of activities which needed to be completed prior to a member of staff completing their probation. We found the practice had a system to monitor staff progress during their induction and had oversight of staff appraisals. We found only 1 member of staff overdue an appraisal but there was a valid reason for this and there was a date scheduled. Staff we spoke with told us the appraisal process was supportive, and they felt comfortable to discuss learning and development needs and career ambitions.</p> <p>We looked at the process used by the practice to maintain oversight of staffs mandatory training compliance and found it operated as intended. The practice used a software system to record completed training and the date of renewal. This software used a traffic light system to show when a member of staff was compliant (green), when training would expire soon (amber) or was overdue (red). We found compliance had improved, Records showed staff were up to date with mandatory training required by the practice training policy. New</p>	

staff had been risk assessed to allow them to work in their roles, had a training plan with due dates and never worked alone because they were always shadowing a member of staff. We also found staff had protected time for learning and development which included dedicated training afternoons.

**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
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022 we found patient correspondence, clinical administration tasks and new patient records which required attention. We were therefore not assured that the practice had an effective system to manage incoming information about patients in relation to care and treatment from other services.</p> <p>At our focused inspection in November 2022 we followed up the highest risks included in our enforcement activity and did not review these findings.</p> <p>At this inspection in April 2023, we found no backlogs in the management of clinical correspondence and there was a system to manage tests results which operated as the practice intended. We therefore found improvements had been made to ensure the practice had an effective system to manage incoming information related to patients care and treatment.</p>	

**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
<p>Explanation of any answers and additional evidence:  At our inspection in July 2022 we found there had been a lack of appropriate action taken or advice provided for patients whose blood sugar reading indicated a diabetic diagnosis. At this inspection of the 5 patients we reviewed as having a potential missed diagnosis of diabetes, we found 3 patients had not been coded as diabetic. Those patients were at risk of not being followed up for monitoring or being referred to national prevention programmes to optimise their health. The practice confirmed they would review these patients and take appropriate action to ensure their medical records were accurate and the patients were aware of their diagnosis.</p> <p>We reviewed information displayed in the practice and on their website and found information about the following was available to patients:</p> <ul style="list-style-type: none"> <li>• National cancer screening programmes for bowel, breast and cervical screening.</li> <li>• Mental health support and charities</li> <li>• Signposting to advice for patients living with lung conditions, rheumatoid arthritis and patients in their maternity period.</li> <li>• Dementia support.</li> <li>• Signal 4 carers – a local organisation which provides free advice, guidance and support to unpaid carers.</li> </ul>	

**Consent to care and treatment**

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient’s mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:  The practice provided evidence that 55 patients had an active DNACPR decision recorded in their clinical records. Our clinical review of notes included a random sample of 5 patients and where a DNACPR decision had been recorded, this identified where possible the patients’ views had been sought and respected. We saw that information had been shared with relevant agencies. We found 3 patients did not have a review date recorded on their DNACPR record and it would have been appropriate for this to be recorded. However, due to the setting these patients lived in, a review had been completed for all of them in the last 12 months. The practice confirmed they would review their process to ensure the clinical system included a review date for all patients DNACPR decisions.</p>	

# Caring

**Rating: Good**

## Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was mixed 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
NHS.UK website	We reviewed all the reviews on the NHS UK website since the inspection in July 2022 (22 reviews) and the feedback was mixed. Positive feedback included staff were kind and caring and when patients needed support, such as using the online booking system, reception staff helped them. Positive reviews also commented on how kind and thorough clinical staff had been when patients received care. Negative feedback focused on queues on the phone and the wait time for a response when an appointment was requested via the online consultation system. Other themes related to delays getting repeat prescriptions and for referrals to be made. We found the practice had acknowledged 20 of the 22 pieces of feedback.
Patient Participation Group (PPG)	We spoke to a member of the PPG who spoke positively about their own experience of care when they saw a clinician. They told us they understood the practice faced challenges due to increased demand and the way the overall healthcare system is managed but they felt the practice could improve and be clearer when it communicated with patients.

## 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)	86.4%	83.3%	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)	84.2%	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)	92.2%	92.6%	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)	60.8%	70.0%	72.4%	No statistical variation

### Any additional evidence or comments

At this inspection in April 2023, the results of the most recent GP patient survey had not been published, therefore we were unable to review the practices' performance against more recent data than was used at the last inspection. We therefore have not provided further comment about the data in the table above as this was published at the time of our inspection in July 2022 and was commented on in that report.

We spoke with the practice about the results of the GP patient survey and found they were aware not all patients had a positive experience when they used the GP practice. To monitor this, the practice also reviewed its performance against other local practices to see whether it was an outlier in any areas and could improve.

Due to patient feedback from the previous GP patient survey and the practices' own surveys and data collection methods, the practice had focused mainly on patients' access to care and the availability of appointments therefore the results of that analysis are referred to under the key question of Responsive. However, we found the practice monitored patient experience through several methods which included:

- Friends and family test.
- Monitoring and responding to reviews on the NHS.UK website
- Verbal feedback given by patients.

	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.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: The practice was able to refer patients to a local social prescriber. A social prescriber provides non-medical advice and directs patients to facilities and services in the community which can improve health and wellbeing.	



Source	Feedback
Give Feedback on Care submissions to CQC.	Due to the methodology used in this inspection, we did not speak to patients directly. We asked the practice to post a link to the 'give feedback on care' questionnaire on the CQC website during the inspection period, however, we did not receive any feedback during the inspection period. Because of this, we reviewed the response received since our inspection in July 2022 and we had received 29 pieces of feedback. None of these provided positive feedback and the themes from these included concerns about access to appointments, lack of clinical staff, delays with repeat prescriptions, unhappiness with the outcome of complaints and rude staff. We explored these themes throughout the inspection process and found the practice was aware of them and had action plans in progress to make improvements.

### 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)	94.1%	88.8%	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
<p>Explanation of any answers and additional evidence:</p> <p>Information on the practice website could be translated into different languages. The practice also told us that information could be converted into easy read and pictorial formats on request. The practice had a hearing loop to support patients with a hearing impairment and had access to an interpretation service to meet patients' individual communication needs.</p> <p>We reviewed the information board at the practice and found details about the advice and support available to patients. This included:</p> <ul style="list-style-type: none"> <li>• The HELP spot – a drop-in clinic for young people to get advice from a GP, sexual health nurse, school nurse and a youth worker about issues ranging from acne, bullying to sexual health and contraception.</li> <li>• Kooth – an online mental health and wellbeing community where people experiencing mental health problems could seek advice, support and guidance.</li> <li>• Signposting to advice for patients living with lung conditions, rheumatoid arthritis and patients in their maternity period.</li> <li>• Signal 4 carers – a local organisation which provides free advice, guidance and support to unpaid carers.</li> </ul>	

We also found a section of the practice website was dedicated to community support services and offered information about:

- Dementia
- Local and national mental health support charities and services.
- Support for elderly patients from Age Concern and Age UK.
- Advice for carers.
- Sandhurst Health Walks.
- Healthwatch.
- Citizens Advice Bureau.
- A website for residents of Bracknell Forest dedicated to advice and support in the local community.

Carers	Narrative
Percentage and number of carers identified.	300 carers (1.59% of the patient list) were recorded on the carers register.
How the practice supported carers (including young carers).	The practice signposted carers to services in the local community who provided advice and support about their rights and entitlements and support they could access to help them in their role.
How the practice supported recently bereaved patients.	The practice told us that when they became aware a patient has died, where the practice has contact details for a member of the patients' family, a GP will contact the bereaved family member and offer their support and condolences on behalf of the practice. Information about the legal requirements when someone dies was also on the practice website.

### 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

At our inspection in July 2022 we rated the key question responsive as Requires Improvement because:

- People were not able to access care and treatment in a timely way.
- Complaints were not used to improve the quality of care.

At our focused inspection in November 2022 we found:

- The practice had completed a feedback exercise to identify where improvements could be made.
- The practice had an action plan to improve appointments for patients.
- The complaints process had been reviewed to ensure it operated effectively.

At this inspection in April 2023, we found:

- The practice analysed patient feedback and management data and used the outcomes to identify improvements for patients.
- The practice had increased the number of appointments available and made changes to make it easier for patients to book appointments and reduce the time patients spent queuing on the phone.
- The practice had systems and processes which provided oversight of current and expected demand to help them plan the delivery of services.
- The complaints process operated effectively and consistently, and complaints were used to identify themes and trends for improvements to the quality of the service.
- When changes were made the practice consulted stakeholders and considered the impact on patients.

### 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

<b>Practice Opening Times</b>	
<b>Day</b>	<b>Time</b>
Opening times:	
Monday	8.00am – 6.30pm
Tuesday	8.00am – 6.30pm
Wednesday	8.00am – 6.30pm
Thursday	8.00am – 6.30pm
Friday	8.00am – 6.30pm
Appointments available:	
Monday	8.30am – 6:30pm
Tuesday	8.00am – 6.30pm
Wednesday	8.00am – 6.30pm
Thursday	8.00am – 6.30pm
Friday	8.00am – 6.30pm

<b>Further information about how the practice is responding to the needs of their population</b>
<ul style="list-style-type: none"> <li>• The practice offered extended hours telephone calls to patients until 7:30 pm on Mondays, Tuesdays, Wednesdays, and Fridays.</li> <li>• Patients had a named GP who supported them in whatever setting they lived.</li> <li>• 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.</li> <li>• The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.</li> <li>• Additional nurse appointments were available outside of school hours for school age children so that they did not need to miss school.</li> <li>• All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.</li> <li>• The practice offered extended hours appointments for patients via the Primary Care Network (PCN). This allowed patients to access care in the evenings and at weekends.</li> <li>• The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.</li> <li>• People in vulnerable circumstances were able to register easily with the practice, including those with no fixed abode such as homeless people and Travellers.</li> <li>• The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.</li> </ul>

## Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022 we found the wait-time for a nurse appointment was 1 week but the average wait time for a routine GP appointment was 5 weeks. We were told this was due to staffing shortages and the practice had adapted the appointment system designed to deliver more urgent on the day appointments to meet demand.</p> <p>At our focused inspection in November 2022, we found the practice had completed an audit and used national guidance to determine the baseline number of appointments for safe working in general practice. This had determined the number of clinical sessions per week was 58. The practice had redesigned the rota and entered into agreements with more locum agencies to deliver this number of sessions. The practice had also redesigned the structure of session to allow clinicians administration time, a short daily team meeting and a mixture of face to face and virtual consultations.</p> <p>At this inspection in April 2023, we asked the practice for evidence of the availability of appointments and found:</p> <ul style="list-style-type: none"> <li>• The next routine nurse appointment was available in 8 days.</li> <li>• The next cervical screening appointment was available in 8 days.</li> <li>• A routine appointment was available with a GP the next day.</li> <li>• The practice informed us there was a significant wait-time for an appointment with the diabetic nurse but in mitigation, GPs were monitoring and managing diabetic test results through routine GP appointments to ensure patients had timely access to care and treatment.</li> </ul> <p>This data demonstrated that the practice had improved the access to appointments through the changes to the appointment structure, introduction of the online request system and the use of locum GPs in the absence of additional employed GPs.</p> <p>We found evidence the practice had made further changes to the way patients could access treatment. For example:</p> <ul style="list-style-type: none"> <li>• The practice had introduced a new online consultation system where all requests for appointments were made. These were triaged by GPs who determined the most appropriate clinician for the patient. Receptionist then contacted the patient to arrange appointments.</li> </ul>	

- Where a patient could not access the online consultation system, the practice would take details of their request and enter this into the system on the patient's behalf to ensure access to appointments was equitable for all patients.
- The online system allowed the practice to forecast future demand for care by giving the practice data such as the number of requests for care by day and the most frequent conditions being treated by the practice.
- We also found the practice actively monitored their appointment data including breakdowns of the number and types of appointments they offered and had comparison data for other practices to ensure they were not an outlier.
- The practice had also reviewed the backlogs of clinical administration, medicine and annual reviews identified by our inspection in July 2022. The number of clinical sessions had been increased in response to reduce the backlog and once this was achieved the practice had made the decision to make a staged reduction in the number of clinical sessions from April 2023.

### 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)	27.2%	N/A	52.7%	Significant variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	44.0%	52.9%	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)	37.8%	51.6%	55.2%	Tending towards variation (negative)
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)	62.5%	68.4%	71.9%	No statistical variation

### Any additional evidence or comments

At our inspection in July 2022 we found the practice was aware that GP patient survey results were significantly lower than local and national averages. The practice explained they had made changes to improve access and there were further plans, but these had not been finalised at that time. The future plans meant the practice had decided to pause recruitment of additional reception and administration staff until the plans were confirmed. We were not assured the practice was doing all it could to respond to feedback from patients about access to appointments.

Our inspection in July 2022 responded to the GP patient survey data in the table above and due to the timing of this inspection we do not have more recent data to comment on. However, we asked the practice about changes that had been made since that inspection and found the practice had analysed the findings to identify the priority areas, had identified the issues they believed were causing the negative feedback and had created an action plan to address them. A sample of the actions taken included:

- A patient survey of 1156 patients suggested that knowing your place in the telephone queue would be helpful. The practice had investigated this and found the current telephone system did not allow this function but there was a possibility of a new phone system in the future which would allow this.
- The reception team had received additional training about the availability of extended access appointments to help meet patients' needs for appointments at a time that suited them.
- The practice had funded additional locum GPs to meet the current demand.
- We also found the practice had previously been in a contractual arrangement for their PCN to answer telephone requests for on the day appointments. These were triaged by a duty GP at the practice who determined whether an on the day appointment was required. The practice explained this system had not operated as the practice had expected. The practice had terminated the contract and had recruited additional receptionists so it could be managed internally by the practice.
- To determine the number of additional staff required to manage their own telephone system for on the day appointments, the practice had analysed the number of calls the PCN had handled on behalf of the practice and minimum staffing levels were planned for 4 receptionists per shift per site. This would allow coverage of the front desk, telephones and online requests for appointments.
- Patients were encouraged to use the online consultation system to request appointments but where they had difficulty using this method would be supported by practice staff. They could request telephone or face to face appointments to meet their needs or preferences.

Source	Feedback
NHS.uk website (formerly NHS Choices)	We reviewed 16 pieces of feedback since our follow up inspection in November 2022 and of these, 9 gave negative feedback about access. The main themes involved were the length of time patients needed to queue to get through on the phone and the practice did not respond to online requests for consultations in a timely manner. The practice had responded to all the comments and provided explanations for the reason where possible, and action that would be taken in response.

### 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.	32
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022, we found the system to receive and monitor complaints was not effective and information about how to escalate a complaint if a patient was unhappy with the outcome was not always included. We also found there was not an effective system to monitor complaints to identify themes or trends so improvements could be made.</p> <p>At our focused inspection in November 2022, we found improvements had been made. An audit had been completed to identify compliance with the practice complaints policy when managing a complaint. An action plan was created to address the key findings and of the 3 complaints we sampled, all 3 included details of how to escalate a complaint if the patient was unhappy. A complaints log to monitor themes and patterns had also been created.</p> <p>At this inspection in April 2023, we found the system had been embedded and operated as the practice intended. The practice provided us with unverified evidence that the number of complaints had reduced by 80% since October 2022.</p> <p>We sampled 3 complaints and found acknowledgements had been sent to patients, the concerns had been investigated and a full explanation about what had happened was given. Where an apology was required, candour had been shown and details of how to escalate the complaint to the Parliamentary Health Service Ombudsman were included in the final response.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A private referral was requested but was not completed in a timely manner.	The practice called the patient immediately to apologise and to confirm what was needed to rectify the situation as quickly as possible. No harm had been caused as a result. An apology was given, and the referral was completed. The practice investigated and found that a backlog of clinical correspondence was a cause of the delay. The status of the clinical correspondence backlog was added as a standing agenda item for all meetings to ensure all relevant staff had oversight and the backlog could be reduced.



## Well-led

## Rating: Requires improvement

At our inspection in July 2022, we rated the key question of providing well-led services inadequate because:

- Leaders could not demonstrate they had the capacity and skills to deliver high quality sustainable care.
- The practice culture did not effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not always act on appropriate and accurate information.
- The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.
- There was little evidence of systems and processes for learning, continuous improvement and innovation.

At our focused inspection in November 2022, we followed up the highest risks included in our enforcement action and found improvements had been made, however we did not rate the practice. Our findings included:

- Systems and processes to identify, manage and mitigate risks existed.
- Quality assurance activity had increased and operated consistently to ensure when things went wrong, learning was identified and shared with staff.
- The practice actively engaged with patients and staff to seek feedback and identify areas where improvements could be made.

At this inspection in April 2023, we rated the practice requires improvement for providing well-led services because:

- Governance systems and processes existed but were not always effective or completely embedded.
- Systems and processes to identify, manage and mitigate risks existed and staff were confident to use them. However, these systems had not identified or effectively responded to all the risks to the health and safety, and wellbeing of patients.
- The leadership had considered the challenges the practice faced now and, in the future, and had a vision and strategy to deliver high quality care and treatment to patients.
- We found a culture where staff at all levels were approachable, and which promoted continuous improvement. The culture also encouraged learning when things went wrong.
- The practice used patient and staff feedback and data to identify and drive improvements to the quality of services for patients.
- Where performance information indicated opportunities for improvements the practice acted. Where internal changes were appropriate, they were made, and where stakeholders were involved, improvements were sought.

## 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
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022, we found leaders did not always demonstrate they understood the challenges at the practice and therefore had not always identified the actions to address them. For example, we identified issues relating to medicines management, infection prevention and control and systems to monitor safety alerts. We also found feedback from staff about leaders was mixed because staff felt there had been a lack of support from GP partners and that they were not approachable.</p> <p>At our focused inspection in November 2022 we followed up the highest priority risks and therefore did not review the findings above.</p> <p>At this inspection in April 2023, we found the GP partners had taken action to address the risks to high quality and sustainable care and to make improvements. For example, at our last inspection the practice had already identified that staffing levels were the highest risk for the practice. They had tried to recruit clinical staff but had not been as successful as they had hoped. At this inspection we found the practice had received a package of financial support from the Integrated Care Board (ICB). This included an external consultant responsible for stabilising the practice and responding to the findings of our previous inspection.</p> <p>The external consultant was also providing practice management and clinical pharmacy support through a contract with the practice. The leadership team and consultant had analysed the findings of our previous inspection, created action plans to prioritise and address the risks identified and developed a strategy to stabilise the practice so it could meet the demands and needs of its patient list. Actions taken included:</p> <ul style="list-style-type: none"> <li>• Reviewing the staffing structure to identify the number of both clinical and non-clinical vacancies.</li> <li>• Terminating an agreement with the PCN to answer telephone requests for on the day appointments and bringing this service back to the practice. There had been a decision to pause recruitment of reception staff however, recruitment had restarted. Analysis had been completed to identify the number of staff needed to meet the estimated demand and recruitment was ongoing but so far, the practice had recruited 6 receptionists and had 3 part-time vacancies still to fill.</li> <li>• The practice had decided to change PCN from Bracknell Forest to The Health Triangle. Previously clinical pharmaceutical support had been provided by the previous PCN, the practice had contracted a pharmacist employed by the external consultancy to ensure this support continued.</li> <li>• Analysis to establish the baseline number of appointments to meet the demand of their patient list.</li> <li>• Redesigning the structure of clinical sessions to deliver services in a way that met patients need including a mix of face to face and telephone appointments.</li> <li>• Increasing the number of clinical sessions to work through the backlogs of clinical care identified at the last inspection and subsequently reducing the clinical sessions to a business-as-usual level once the backlogs were cleared. Control measures and mitigations were in place should there be peaks in demand but, the new online consultation system helped the practice to forecast demand more effectively.</li> </ul>	

Staff we spoke with told us they found leaders were visible and approachable. The practice had introduced a daily meeting called a 'huddle' which was used to deliver key messages and check on staff wellbeing. Staff also told us they felt comfortable to approach and ask questions of the leadership team and that if they did, they were confident they would be given honest answers.

Although the practice was receiving practice management support, 2 existing members of staff had been identified to become operations managers. These staff shared responsibilities for managing the reception and the secretarial teams as well as recruitment, HR matters and complaints.

### 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>At our inspection in July 2022, we found the practice had aims of how they would deliver high quality, sustainable care. However, due to the challenges the practice had faced during the previous 2 years, there had been limited resources to develop and deliver these strategic aims.</p> <p>In response to the findings of our previous inspection the ICB had provided funding to the practice for the external consultancy to work on stabilising the practice and developing a strategic plan to ensure patients received high quality sustainable care in the future.</p> <p>The leadership had looked at their current systems and processes and found their working arrangements with their previous PCN had not operated as they had expected. To make improvements the GP partners had decided to change PCN, and further strategic changes were being considered but had not been confirmed at the time of the inspection. The practice had developed a vision and strategy to ensure patients would receive high quality care in the future, staff were aware of their roles in achieving this and where appropriate, the practice had consulted with their PPG as representatives of the patients and other strategic external partners as these plans were developed.</p>	

## Culture

### The practice culture 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>At our inspection in July 2022, we found examples incidents which should have been reported as significant events but had not been. We explored this with the leadership and found there was a culture of reluctance from staff to raise significant events. Staff told us they did not feel valued and that there was additional pressure to reduce backlogs. We also found not all staff had completed equality and diversity training.</p> <p>At this inspection in April 2023, we found staff were confident about when and how to raise significant events and were comfortable to do so. While on site, we found an issue with the management of prescription stationary and the member of staff we were with spoke confidently of the next steps they would take to address this which included an audit and raising a significant event. We were shown evidence later that this had been completed. Other staff also spoke confidently about the process and that they were happy to record incidents as significant events and viewed these as a learning opportunity.</p> <p>Staff we spoke with told us they felt part of a team and there had been a lot of changes and improvements in the practice very quickly, including staff changing roles and recruitment. Staff told us that changes were communicated effectively, all staff knew who to ask if they had a problem and where to find information if they needed to. They were also confident that if they raised an issue they would be listened to, and action would be taken.</p> <p>We found all staff had completed equality and diversity training except recent starters in the non-clinical teams. However, we found evidence this training was part of their induction process and the decision to prioritise other training had been risk assessed with control measures in place which included the fact those staff would not work unsupervised until they had passed their induction.</p> <p>Of the 3 complaints we reviewed we found candour was shown in responses and that where apologies were necessary, these were given.</p>	

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

Source	Feedback
Staff feedback	We spoke with several staff, and all reported they felt supported in their roles, were comfortable to make suggestions for improvements or ask if they did not know something. They were proud to work for the service and had always wanted the best outcomes for the patients.

**Governance arrangements**

**There were clear responsibilities, roles and systems of accountability to support governance and management, but these did not always operate effectively.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P
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 inspection in July 2022, we found that governance systems and processes were not established and were not operating effectively. Risks identified at that inspection had not always been identified by the practice. For example, appropriate oversight of medicine safety alerts, documentation of care plans and monitoring of patients prescribed high risk medicines. Additionally, we found oversight of training was not effective as the training matrix did not accurately reflect training compliance.</p> <p>At our focused inspection in November 2022, we found improvements had been made. For example, the practice had identified that patient access was a performance issue and had made changes to improve this. We also found changes had been made to the process to monitor two-week wait referrals. However, not all changes to systems and processes had operated consistently because we found some administrative tasks had been individual responsibilities and when that member of staff had been absent, the task had not been completed. For example, checking the fire alarm system.</p> <p>At this inspection in April 2023, we found tasks had become team responsibilities and management had oversight of all tasks. There was a system to identify when tasks were due or overdue and this was monitored continuously to ensure tasks were completed. We checked the records for fire alarm testing and saw evidence these systems were checked routinely and in line with the practice policy.</p> <p>Our previous inspection had identified backlogs of clinical administration tasks including summarising of new patients notes, prescription requests and actioning correspondence. We found the practice had analysed the causes of the backlogs and found staffing shortages were a reason but there were also external factors. For example, the local pharmacy was sending large requests for prescriptions. The practice held a meeting where they identified the impact on patients which included a delay for processing the request, sometimes up to 4 days. The practice had promoted the use of digital services such as the NHS digital application (app) and other</p>	

apps which could be used by patients to request prescriptions instead of through the pharmacy. The practice reported this had resulted in the workload being spread more evenly across the week. Although an audit of data to demonstrate the reduction had not been completed, the practice provided evidence of the reduction in requests from the pharmacy and when our GP specialist advisor completed remote clinical searches, we found no backlogs and the practice was processing the requests made that day.

Although we found improvements had been made to the governance arrangements at the practice since our inspection in July 2022, not all the changes were completely effective, embedded or operating consistently and further improvement was needed. For example we found the following:

- A system to manage and respond to medicines safety alerts from the MHRA had been introduced in response to the findings at our July 2022 inspection. However, we found 2 examples of historic safety alerts which had not been responded to effectively because patients had either been prescribed medicine contrary to the alert, had not been told of the risk of taking the medicine or had not been given an emergency steroid card per the guidance. We saw evidence to mitigate some of the risk but, we were not assured the system, as operated, effectively identified all patient safety alerts to ensure patients received safe care and treatment.
- The system and process to monitor and track prescription stationary when in use in the practice had not operated effectively and, the practice's own audit or quality assurance processes had not identified this. In mitigation, the practice acted immediately to fix the ineffective process on the day of the inspection and shared details of the new system after the inspection site visit. However, because the system was new, the practice had not yet been able to review it to confirm it was operating as intended. The practice confirmed they intended to do this in in September 2023. Due to the change happening after the inspection we were not able to confirm the process was embedded.
- The system to record the status of staff immunity to communicable diseases had not operated as the practice intended. However in mitigation, audit and quality assurance processes had identified the failed process prior to the inspection and the practice had acted in response by starting a programme of blood tests to check staff immunity prior to the inspection. After the inspection, the process was complete and staff members with inadequate immunity had been identified and would be offered vaccinations.
- Coding of patients' records was not always completed in a timely manner to ensure clinicians had accurate, up to date information. For example, patients with a diagnosis of diabetes had not been coded as diabetic, this was contained in their notes. In mitigation, their test results had been reviewed and follow up appointments with the specialist diabetic nurse had been indicated as required by the clinician reviewing the results. However, coding when a diagnostic test indicated a condition would improve the quality of care and ensure patients are included on recall lists for follow up appointments, monitoring tests, and national prevention programmes.
- Medicine and condition reviews for patients with long term conditions and serious illnesses had been completed, however they did not always follow a structured format to document what had been reviewed. Including this in the process would improve the quality of the information in the patient's clinical record and assist others in providing high quality care.

## Managing risks, issues and performance

**There were processes for managing risks, issues and performance, however they were not always effective and opportunities for improvement existed.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	P
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.	P
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022, we found processes to identify and manage risks were not effective. For example, we found the system to identify and manage IPC risks was not effective and control measures were not always appropriate. The management of health and safety systems was not effective, and systems and processes related to safeguarding were not always effective to ensure abuse and improper treatment of service users was prevented.</p> <p>At our focused inspection in November 2022, we found improvements had been made. The practice had recorded significant events for all the findings at the previous inspection, created action plans to respond to the risks identified and completed some but not all the actions. The highest risks had been prioritised. We found that opportunities to learn from significant events were taken because any events raised were included as a standing agenda item at the team meeting. We also found the practice risk register was colour coded to prioritise risks and control measures were assigned to each risk.</p> <p>At this inspection in April 2023, we found these systems and processes had continued to operate as the practice intended and had become embedded. We also found the leadership and management had clear oversight of the risk register which was regularly reviewed to ensure that appropriate mitigation and control measures were in place to reduce, manage or remove the risk.</p> <p>We found where performance issues were identified, for example, the backlog of prescription requests, the practice used data and information to monitor the impact of changes they made. Because these changes had been successful with 1 pharmacy, the practice told us they intended to request a meeting with another local pharmacy to try and further improve patient experience. We found a quality improvement programme was in place and saw evidence of audits of prescribing by non-medical prescribers. We also found audits had been used to optimise patient care, for example for patients prescribed DOACs.</p> <p>We were shown evidence of a draft equality and health inequalities assessment that had been completed as the practice developed its vision and strategy for the future. This had been completed to understand the impact of any changes and to ensure they would deliver high quality and sustainable care.</p> <p>However, we also found example where governance systems had not effectively identified risks and opportunities to improve performance. For example,</p> <ul style="list-style-type: none"> <li>• The practice system to monitor and track prescription stationary had not operated effectively. This posed the risk of fraudulent use of stationary, and safety risks for the public.</li> </ul>	

- The medicines safety alert system had improved, however we still found examples of historic alerts which were not always responded to effectively. Further improvement to the system was required to ensure it responded to all medicine safety alerts effectively.
- Coding patients when diagnostic tests indicated a diagnosis would mean their care was optimised by ensuring they were recorded on recall systems for testing and monitoring, and national prevention programmes.

### 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.	P
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022, we found data was not used to monitor performance and staff and management were not held to account. This was because the lack of summarising of new patient records, delays to two-week referrals and the lack of monitoring of medicines safety alerts meant we were not assured the practice was acting on or using information appropriately.</p> <p>At this inspection in April 2023, we found improvements had been made. The practice had made changes to the systems and processes to manage clinical correspondence, two-week wait referrals and medicines safety alerts. We found the backlogs had been reduced and audit was used to ensure compliance with the policy and process to avoid delays and backlogs recurring. However, further improvements were needed because not all these systems had operated as consistently as the practice had intended, for example the monitoring of patients affected by patient safety alerts.</p>	

### 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
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022, we found the practice did not always involve the public, staff and external partners to sustain high quality care because although a patient engagement event had been held in April 2022, the practice was not able to demonstrate that action had been taken on the feedback. Staff surveys did not focus on what the practice had done well and did not provide an opportunity to raise concerns about areas for potential improvement.</p> <p>At our focused inspection in November 2022, we found the practice had completed a survey of 1156 patients to identify what they did well and where they could improve. At the time of the inspection the survey had closed recently so the results had not been analysed.</p> <p>At this inspection in April 2023, we found the results of the survey had been analysed along with the results of the 2021/22 GP patient survey to establish the areas with the biggest deterioration in performance and an action plan had been created. The areas being focused on were improving:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• The percentage of respondents who describe their experience of making an appointment as good.</li> <li>• The percentage of respondents who are satisfied with the general practice appointment times available.</li> <li>• The percentage of respondents who find the receptionists at this GP practice helpful.</li> <li>• The percentage of respondents who say they have had enough support from local services or organisations in the last 12 months to help manage their long-term condition(s).</li> </ul> <p>The practice had compared themselves to the ICB average and had created an action plan to respond. Some of the completed actions included:</p>	

- To reduce the demand on the phonelines patients had been encouraged to sign-up to the NHS APP and a new online request system had been introduced to manage requests for appointments and electronic consultations.
- To meet the increasing demand for appointments, the practice had increased their use of GP locums.
- In response to feedback that some patients did not find the reception team helpful, coaching had been given and a daily huddle meeting was used to raise and discuss any issues.
- To help patients get further support to manage their long-term conditions, the practice had created a community support page on practice website to signpost patients to additional information and support.

Feedback from Patient Participation Group.

**Feedback**

We spoke to a member of the Patient Participation Group (PPG) who explained their meetings used to cover issues patients were experiencing and the support the PPG could offer. However, more recently the meetings had focused on the changes being made because of the CQC inspections. We were told some members of the PPG were keen to deliver more patient engagement events, but the group understood the practice had needed to prioritise making changes and improvements to the findings from our inspection before these could be planned.

**Continuous improvement and innovation**

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in July 2022, we found new systems had been put in place by the new practice manager and deputy manager to identify, prioritise and manage risks at the practice. However, these were very recently introduced and had not identified several the concerns found during the inspection. For example, lack of medicine reviews, management of safety alerts and backlogs of workflow administration. We also found many staff had not received appraisals which meant the practice had not explored options for staff to learn and develop. Incidents which should have been recorded as significant events and learned from had not been and when they were, learning was not routinely shared with staff.</p> <p>At this inspection in April 2023, we found the practice had taken action to ensure patients taking high risk medicines or with long term conditions received monitoring and reviews in line with national guidance. We found there was a policy and process for management of patient safety alerts which categorised the alert by risk and depending on the level of risk, had different actions to be taken. We also found all tasks in the workflow inboxes had been viewed and filed with action taken.</p>	

## Examples of continuous learning and improvement

We found evidence that staff were confident about how and when to raise a significant event. We observed the proactive and confident approach taken by a member of staff when an incident was identified and saw they did not fear being blamed but rather they wanted to record the incident to ensure appropriate action was taken and learning would be generated and shared.

We also found evidence that staff were comfortable to make suggestions when they identified opportunities to improve systems and processes for the benefit of the practice and patients. For example, the prescription team highlighted a local pharmacy's process contributed to the uneven workload and backlog of repeat prescription requests. Once identified, the practice took action to improve the relationship with the pharmacy which resulted in more manageable workloads and no backlog.

### 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.