

Inspection Evidence Table

Old Town Surgery

(1-9882884966)

Inspection Date:

Date of data download: 12/10/2023

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a safeguarding system and policy in place for vulnerable adults and children reviewed in June 2022 to ensure information was correct and kept up to date. There were designated safeguarding leads who held oversight of new and existing safeguarding concerns. Local arrangements and key contacts for making a safeguarding referral were available to staff. • Senior managers discussed safeguarding and vulnerable patients at regular monthly clinical governance meetings. Relevant information was recorded in patient records we sampled. 	

- The practice worked across the partnership Primary Care Network (PCN) and shared safeguarding processes and procedures, which gave guidance for staff to assist those patients who may be vulnerable.
- All staff had received safeguarding training assessed by the practice as being appropriate to their role and this was refreshed when required, in line with practice policy.
- Enhanced Disclosure and Barring Checks (DBS), to check the criminal record for someone applying for a job role, were carried out on all clinical staff. For those staff who were not clinical, the practice had carried out a risk assessment to demonstrate why an Enhanced or Standard DBS check had not been undertaken.
- Clinical staff members had chaperone responsibilities as part of their role.
- The practice had a system to identify vulnerable patients on record and there were regular discussions between the practice and other community care professionals such as health visitors and social workers when needed.
- The practice's clinical records system had a safeguarding alert flag for every new consultation record as a reminder for clinicians to record safeguarding concerns or relevant patient information.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a recruitment policy in place, which had been reviewed in July 2023 to ensure the most up to date legislation and recruitment guidance was adhered to. The practice had maintained records in relation to immunisations staff had received. • The practice had a dedicated induction programme, in addition to a starter pack for locum and temporary staff. • We carried out recruitment checks in relation to three members of staff which contained all the required information as per practice policy. 	

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: September 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: November 2022	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Health and safety risk assessments had been reviewed in September 2023. This included risks in relation to lone working; premises, environment and security; slips, trips and falls. Risks to service users were identified and mitigated appropriately. 	

- There was a fire policy last reviewed in September 2023, which outlined evacuation procedures. We identified that the fire training had been completed by staff within practice policy timeframes.
- The fire risk assessment carried out had identified areas for improvement. Remedial actions had been taken such as smoke seals fitted to fire resisting doors and a lift service completed in June 2023.
- Annual assessments including emergency lighting testing had been completed in November 2022. The fire extinguishers were serviced in March 2023.
- The practice conducted fire alarm tests bi-weekly, we saw evidence of records that had been maintained to demonstrate this. The practice had completed a fire drill in August 2023 and a full evacuation in April 2023 in line with practice fire policy timeframes. The practice shared the premises with other healthcare providers and agreed full building evacuation as part of annual fire risk procedures.
- Portable appliance testing had been completed in August 2022 and equipment calibration had been completed in September 2023. There were no issues identified as actions that required improvement.
- Legionnaire checks of the water system had taken place in August 2023. Records of monthly water checks and flushing records were completed by staff to ensure the water system was safe. Oversight was provided by the infection prevention and control (IPC) lead with the practice manager. The assessment deemed the premises compliant.

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: August 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The infection prevention and control (IPC) policy was last reviewed in June 2023. Standard operating procedures were in place and had been reviewed by the practice’s IPC lead. This included guidance for staff relating to cleaning arrangements; training and induction requirements; risk assessment and audits; clinical waste; clinical procedures and injuries and incidents. The IPC lead was able to demonstrate compliance with national guidelines. • Appropriate arrangements were in place to manage and dispose of clinical waste. We saw that clinical waste was stored securely prior to being disposed of. Certificates of clinical waste disposals were kept by the practice to demonstrate this. • Appropriate measures were in place to ensure the premises was clean and that sufficient levels of personal protective equipment (PPE) were available where required. • Staff were up to date with IPC training. There was an IPC induction checklist for new staff. • The practice had completed an annual IPC audit in August 2023. Actions had been taken to address shortfalls identified in this area, including steam clean chairs throughout the practice waiting area; vinyl seal, skirting and flooring required attention in treatment rooms, in which the practice had booked contractors for October 2023. The practice had plans in place to reintroduce IPC hand-hygiene spot check audits. Compliance to the action plan was to be assessed at the next IPC audit. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a team of 6 GPs who provided a range of patient facing appointments including urgent and routine appointments as well as home visits. The practice used a pharmacist to assist with providing urgent triage appointments two days a week. Nurses were used to provide long-term condition clinics such as asthma and diabetic reviews and specific appointments such as immunisation and cancer health screening. We saw evidence of staff rotas completed four weeks ahead of time. There were processes in place to manage absence including “buddy” cover arrangements. The practice had adequate clinical staffing arrangements to ensure in the event of emergency there was no lone working. The practice was able to access additional staff who worked across the primary care network (PCN), for example, a dietician and a mental health support worker. There was a recruitment policy for new members of staff, including an induction procedure for training and guidance for locum and temporary staff. 	

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:</p>	

- During this inspection, we conducted a review of patient records within the practice’s clinical record system and identified records were managed to ensure patients received safe care and treatment. Records contained relevant, accurate and up to date information in line with current guidance.
- There was a dedicated administration team of staff who were responsible for ensuring urgent and routine patient referrals were actioned and followed up. For urgent referrals, there was a system for staff to check patients had attended their appointment.
- The practice had a system in place for processing new patient information and summarising notes. The practice had kept up to date with patient summarising to ensure accurate information was available for clinicians.
- There was a clear documented approach to the management of test results. Staff we spoke with were aware of their roles in relation to test results and tasks were set for clinicians to review these on the same day. The practice had a ‘buddy’ system to cover clinician absences for outstanding patient results. During our clinical searches, we found that the practice was up to date with reviewing patient pathology and radiology results.

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.78	0.85	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2022 to 30/06/2023) (NHSBSA)	10.6%	8.9%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	5.08	4.76	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	119.2‰	123.0‰	129.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.86	0.57	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	7.5‰	5.9‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	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 medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	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> <ul style="list-style-type: none"> Clinical supervision was managed by the practice’s lead GP. They provided mentorship for a pharmacist at the practice who was undertaking their independent prescribing qualification at the time of inspection. Records were in place to ensure their prescribing was appropriate and safe. The practice held routine clinical meetings to discuss any updates to national best practice treatment guidelines including patient safety alerts. There were 2 other members of staff who were non-medical prescribers at the practice. The practice had an “open door” policy for staff to raise clinical queries including prescribing with the on the day duty GP. However, there was no formal system or process to routinely review and record the prescribing competency of the 2 non-medical prescribers, providing shared learning from clinical cases 	

to ensure care was provided safely and within scope of competency. The practice was taking action to review the system for supporting staff in place.

- During this inspection, we undertook remote searches of the practice’s clinical records system. From our search findings, we determined that patients who had been prescribed high-risk medicines had been appropriately monitored and reviewed, in line with National Institute for Health and Care Excellence (NICE) guidelines. For example, we identified 4 patients prescribed methotrexate, a medicine for inflammatory conditions. We reviewed all 4 clinical records and showed all patients had received the appropriate monitoring. We identified 110 patients prescribed Angiotensin-converting enzyme (ACE) inhibitors or Angiotensin II receptor blockers (A2RB), medicines used to treat high blood pressure. Of those patients, 10 had not received the appropriate urea and electrolytes (U+E) blood monitoring for the previous 18 months. We reviewed 5 patient records and identified the practice had robust recall processes for patients with outstanding monitoring. We identified 4 out of the 5 patients had either declined or did not respond to multiple recall invitations and had subsequently reduced prescription amounts as part of the practice’s medicine management procedures.
- There was a process for the safe handling of requests for repeat medicines and evidence of structured medicine reviews for these patients. Policies were in place for medicine management, such as those which set out the monitoring required for high-risk medicines.
- We reviewed a randomised sample of five medicine reviews and found that the practice had recorded the appropriate detail. Patients had treatment plans in place with regular monitoring to ensure safe care and treatment. The practice had an improvement plan in place with a target for further GP training for clinical system and comprehensive quality medicine review process.
- Emergency medicines were not always stored appropriately, we found that keys to locked medicine stock was available in non-restricted public areas. Staff undertook stock checks, including a review of expiry dates. After the inspection, we saw evidence that access to medicines had been appropriately reviewed to ensure this was only available to staff.
- Medicines had not always been risk assessed to ensure appropriate medicines were included in stock, such as midazolam, medicine to treat epileptic episodes and naloxone, medicine used to treat opioid overdose. However, for medicines such as atropine (medicine used to treat vasovagal syncope), PCN staff who conducted intrauterine device (IUD) coil clinics brought in this type of emergency medicine stock during clinics at the practice. The practice had an action plan in place to develop individual risk assessments as part of the medicine management policy.
- We found evidence that the practice had not displayed the appropriate signage for the storage of oxygen in one of the treatment rooms. After the inspection, we were provided evidence to show that oxygen storage signage had been updated in the treatment room to reflect Health & Safety Executive legislation. There was a service agreement in place for replacements when oxygen levels were low or expired.
- Medical equipment included a defibrillator, in which staff undertook operating checks and expiry checks of the defibrillator pads for adults and children.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y

Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	6
Number of events that required action:	5
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff were clear on their roles to raise safety incidents and how to report concerns appropriately. • The practice was able to evidence learning and the dissemination of information relating to significant events. Following a significant event, the practice advised that learning from the event was investigated and discussed at multi-disciplinary team meetings. Formal minutes were recorded and shared to staff via email correspondence. 	

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

Event	Specific action taken
An incident occurred where a potential misuse of repeat prescriptions was requested by a patient and issued by the practice.	The incident was investigated by senior clinical team to find the root cause including a thorough review of medical records. The patient's next of kin was contacted and the patient referred to the mental health practitioner in line with the agreed treatment plan. The practice had updated their medicine management processes and identified no harm had taken place despite a risk of the type of medicine misuse. The practice had implemented routine reporting to identify any over-requesting of medicine through early prescriptions. Learning was shared through a significant event meeting to minimise the risk of reoccurrence.
An incident occurred where an incorrect patient's Recommended Summary Plan for Emergency Care and Treatment (RESPECT) form had been uploaded to a patient record.	The incident was reviewed openly and transparently. The patients were contacted and an apology was provided in line with the duty of candour. The practice had reviewed the administration scanning procedures and made changes to ensure additional patient verification checks were completed. Learning had been shared with staff through a significant event meeting to minimise the risk of reoccurrence.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	

- We saw examples of actions taken on recent safety alerts. There had been two MHRA safety alerts published in 2022 relating to teratogenic medicines that if administered to a pregnant mother can cause harm to the fetus. One alert related to Pregabalin, in April 2022, and one related to Topiramate issued in July 2022. For patients prescribed these medicines, action should be taken to advise the patients of risks and to give contraception advice and medical care. Our clinical searches identified 42 patients were prescribed these medicines. We reviewed 5 records and found that 4 out of the 5 patients had the risks associated with these medicines discussed at consultation. The practice had attempted to contact and invited the other patient for consultation to review. We saw updates to patient records to indicate this alert had been identified and where appropriate patients were on contraception treatment.
- The provider was able to demonstrate that all relevant safety alerts had been responded to appropriately and that routine patient searches had taken place to ensure safe care and treatment.

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y

The practice prioritised care for their most clinically vulnerable patients.

Y

Explanation of any answers and additional evidence:

- GPs referred patients to secondary care and used two-week wait (2ww) pathways where appropriate. A two week wait pathway is where the cause of a patients presenting condition may be in relation to cancer. We saw the practice had kept up to date with processing two-week wait referrals to ensure patients were seen in a timely way. Safety netting was in place to confirm patients had an appointment upon lack of receipt of referral.
- All 2ww referral responses were sent to the referring clinician for learning from patient outcomes and ensure cancer referral pathways were correctly followed based on patient symptoms. Clinicians had designated follow-up appointment slots to allow for continuity of care, where cancer reviews had taken place.
- The practice had a process in place to ensure patients with a cancer diagnosis were informed of the support available and cancer care reviews were completed as per national guideline timeframes. The practice monitored compliance to patient pathways through on-going routine reporting and learning event meetings held annually.
- Patients were given advice on what to do if their condition deteriorated, for example, call backs or contact with the out of hours service. Respective communications between the out of hours service was highlighted when we spoke with senior staff, including the transfer of discharge notifications, changes to patient medication and protected appointment slots bookable by the out of hours service.
- The practice had a 'same day care pathway' which offered clinically vulnerable patients or patients requiring urgent care, triage appointments to ensure patients were receiving accessible and effective care.

Effective care for the practice population

Findings

- 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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice is part of a wider network of GP practices, Wyvern Health Partnership, which is a registered Primary Care Network (PCN). Patients registered at these practices are also part of the PCN and are able to benefit from services offered including; a Care Home and Frailty Service; dietician services; a mental health practitioner and a social prescriber team.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- 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 asthma were offered an asthma management plan.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- During this inspection, we undertook remote searches of the practice's clinical records system. From our search findings, we determined there was clear oversight of systems and processes to ensure monitoring was in place for patients with long-term conditions, such as through recall reporting and patient invitations for blood monitoring. For example, we identified 243 patients with hypothyroidism, a condition which results in low activity of the thyroid gland. 7 of those patients did not receive the appropriate thyroid function (TFT/TSH) blood monitoring within the last 18 months. We reviewed 5 patient records and found 4 of those 5 patients were either newly registered or had been sent multiple invitations for monitoring review. 1 of the 5 patients had their thyroid monitoring in secondary care settings.

We identified 15 patients with chronic kidney disease (CKD) stages 4 or 5. 1 of which had not received the appropriate renal blood monitoring in the last nine months. We saw evidence that this patient was being managed and monitored in secondary care settings.

We identified patients who were diagnosed with asthma were reviewed to ensure their treatment was optimised in line with national guidance. Out of 1294 patients with asthma, 45 had been prescribed 2 or more courses of rescue steroids. We reviewed 5 patient records and found patients were followed up within a week of presenting with acute exacerbations of asthma, as outlined in the 2014 National Asthma Audit and subsequent National Institute of Care Excellence (NICE) guidelines. Patients had steroid cards issued where appropriate and had asthma management plans in place.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e.	80	83	96.4%	Met 95% WHO based target

three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	71	78	91.0%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	72	78	92.3%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	72	78	92.3%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	72	79	91.1%	Met 90% minimum

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

Any additional evidence or comments

- The practice had met the World Health Organisation (WHO) minimum target of 90% in all five childhood immunisation targets. Clinical staff we spoke to were aware of the practice's initiative to provide further education to assist young families in the importance of these immunisations.
- The practice monitored Did Not Attend (DNA) appointments with appropriate follow-up processes.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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)	66.7%	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)	72.1%	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). (3/31/2023 to 3/31/2023) (UKHSA)	72.5%	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) (4/1/2021 to 3/31/2022) (UKHSA)	62.9%	59.5%	54.9%	No statistical variation
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Any additional evidence or comments
<ul style="list-style-type: none"> The practice did not meet the minimum 80% target of eligible patient uptake of cervical screening. The practice combined cervical cancer screening appointments with other acute or routine patient needs where possible. At the time of inspection, cancer screening appointments were available to book in advance. The practice had arrangements in place with the Primary Care Network (PCN) to offer extended access appointments to improve the uptake of cervical screening alongside the local contraceptive service. We saw evidence of unverified 5-year data demonstrating the practice had met the 80% minimum target.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> The practice had a quality improvement audit program which was reviewed throughout the year by the clinical team, with findings discussed and learning shared at an annual practice meeting event. For example: The practice completed a 2-cycle quality improvement audit following the safety alert on the issue of steroid emergency cards for patients with adrenal issues. <p>Cycle one in May 2021 identified 62 patients who required and subsequently were provided with a steroid emergency card through SMS text or letter invitation reviews. The practice implemented clinical records reporting and applied an appropriate code within patient records.</p> <p>Cycle two in August 2023 identified a further 74 patients who were also provided with a steroid card as per national guidance. The practice reflected upon the findings and planned to implement routine reporting every 6 months to ensure patients are safely prescribed corticosteroids with the issue of steroid emergency card.</p> <ul style="list-style-type: none"> The practice had completed an audit in relation to Non-steroidal anti-inflammatory drugs (NSAID) prescribing to identify the number of patients over the age of 70 that were prescribed NSAIDs such as Aspirin and Clopidogrel to ensure these patients are also issued a stomach protector; proton pump inhibitor (PPI) or H2 receptor antagonist due to the risk of gastro-intestinal (GI) bleed. 	

Clinical records searches identified 86 patients who were not prescribed a stomach protector or PPI whilst taking an NSAID. Patients were contacted and reviewed to ensure safe care and treatment was given in line with national guidelines. The practice had implemented 6 month routine reporting for this safety alert to ensure patients were appropriately managed.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. Processes were being developed to embed staff competency checks.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff mandatory training deemed by the practice training policy was completed and up to date. There was a system in place to ensure records were checked regularly. • Staff told us they were given protected time to complete training. • We observed records which verified appraisals were conducted with staff, staff performance was monitored and objectives were set. Staff were supported to meet the requirements of professional revalidation, including registrations with the General Medical Council (GMC) and Nurse Midwifery Council (NMC), where appropriate. There was no formal system or process to routinely review and record the prescribing competency of the non-medical prescribers, providing shared learning from clinical cases to ensure care was provided safely and within scope of competency. The practice had implemented an action plan to formalise clinical supervision to include a review of randomised samples of clinician consultation records as part of performance competency and quality development for staff. Including, qualitative notes assessment and a review of patient treatment planning to ensure care is in line with national guidelines. • There was a recruitment policy which outlined the process for new starters, including locum and temporary. Induction checklists were in place for new staff members for probationary review. 	

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had a system to manage communication between services about patients so that they received consistent and co-ordinated care. For example, meetings took place between the local Out of Hours service and the provider for the safe handover of clinical records and treatment plans of patients moving between the services. The practice used a task management system which clinicians used to raise specific clinical tasks with the lead GP outside of the set daily meeting as a safety mechanism.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had arrangements to provide care services at a local nursing home. The practice provided weekly ward rounds, completed by a GP partner and a visiting nurse practitioner. They were supported by oversight from a community matron.End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.Daily home visit appointments were available to those patients that were vulnerable and high risk, as well as health checks and routine care, such as for patients with long-term conditions.Same day appointments and longer appointments, as part of reasonable adjustments, were offered when required.There was a drive to improve social prescriber links across the partnership primary care network (PCN), with a care navigator leading patient pathways within the partnership. At the time of inspection, we saw	

evidence of social prescribing schemes for dietetic services, weight management, smoking cessation, mental health services and physiotherapy.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • During a review of clinical records, we identified that consent and decision making was recorded in line with legislation and guidance. • We reviewed five patients with a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records to consider whether the DNACPR had been prepared and agreed appropriately. The records were signed and authorised with the latest reviews reviewed where applicable. Recommended Summary Plan for Emergency Care and Treatment (RESPECT) forms were used for end of life patients where appropriate. 	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We reviewed the most recent information available for the practice regarding patient satisfaction. This included information from the national patient survey up to July 2023 and recent enquiry trends. We also looked at information on NHS.uk website and information from Healthwatch which highlighted that patients were treated with kindness and respect. 	

Patient feedback

Source	Feedback
<ul style="list-style-type: none"> Observations made during the inspection 	<ul style="list-style-type: none"> We carried out observations in the reception area where patients attended in person, as well as the administrative area where staff took telephone calls. Staff were helpful and courteous toward patients and were compassionate in their approach.
<ul style="list-style-type: none"> NHS.uk website (formerly NHS Choices) 	<ul style="list-style-type: none"> At the time of the inspection, there had been one rating and review for the period of October 2022 to October 2023. The feedback was a four-star review. Patient commented on reflected positive for accessibility and how caring and professional staff were.
<ul style="list-style-type: none"> 'Friends and Family Test' (FFT) patient feedback 	<ul style="list-style-type: none"> The practice received 754 responses to the 'Friends and Family Test' (FFT) feedback survey from August 2023 to the time of inspection. A total of 96% recommended the practice, with 647 'very good' and 78 'good' responses. Trends were reviewed and discussed at practice meetings on a monthly basis, identifying where poor or very poor feedback was given. The practice implemented a 'you said, we did' feedback response system to showcase improvements to the service.

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 (01/01/2023 to 30/04/2023)	95.6%	88.4%	85.0%	Variation (positive)
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 (01/01/2023 to 30/04/2023)	93.8%	87.2%	83.8%	Tending towards variation (positive)
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 (01/01/2023 to 30/04/2023)	99.5%	95.3%	93.0%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	85.7%	76.1%	71.3%	No statistical variation

	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: <ul style="list-style-type: none"> The practice had a designated community services area within the reception. The practice had worked with the Primary Care Network (PCN) and had access to a mental health support worker, dietician and a social prescriber to ensure patients had access to community and advocacy services. The practice had a care co-ordinator to oversee and support patient pathways. The practice held a carers registration list. Carers had access to monthly social support meetings which helped provide community engagement. 	

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 (01/01/2023 to 30/04/2023)	97.6%	92.8%	90.3%	Tending towards variation (positive)

	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Interpretation services were available as well as leaflets in other languages and in easy read formats, including braille. 	

Carers	Narrative
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Percentage and number of carers identified.	<ul style="list-style-type: none"> The practice had identified 133 of the patients on their registration list as being carers. This was approximately 1.4% of patients.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> The practice's computer system alerted staff if a patient was carer. New patient registration forms included information to highlight if patients had caring responsibilities. The practice had access to refer patients to the PCN led monthly carers community clinics. Supportive information was shared with attendants such as local Carers UK services. Carers were invited to annual health screening and vaccination clinics.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> Staff told us that if families had experienced a bereavement, the practice contacted them. Further advice was also offered as required and families were signposted to relevant support groups. The practice had healthcare partnership links to refer patients to bereavement counselling for children and adults.

Privacy and dignity

The practice respected / did not always respect 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. 	

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y

The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6:30pm
Tuesday	8am – 7:30pm
Wednesday	8am – 6:30pm
Thursday	8am – 7:30pm
Friday	8am – 6:30pm
Appointments available:	<p>Urgent and routine face to face appointments with a GP were available daily. At the time of inspection, we identified the practice had at least 30 GP appointments available, with at least 2 GPs working at the practice on each weekday.</p> <p>Appointment triage telephone calls and face to face triage appointments were available between 8:30am to 12:30pm on Tuesdays and Thursdays, led by a triage pharmacist and duty GP.</p> <p>The practice worked with the partnership primary care network (PCN) to provide additional access to pre-booked appointments on Tuesday, Wednesday and Friday mornings from 7:30am and Wednesday and Friday evenings 6:30pm to 8pm. Extended access was available at Wyvern Health practice sites on Saturdays 8:30am to 12:30pm.</p>

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> • Patients had a named GP who supported them in whatever setting they lived. • The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice adjusted the delivery of its services to meet the needs of patients with a learning disability, such as annual reviews and vaccination clinics.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a process in place to ensure appointments were available to be booked 3 weeks ahead of time. Mechanisms were in place to increase appointment capacity when required through staff rota planning and the usage of locums. • Home visit appointments were available daily for those patients who were housebound or vulnerable. • There were 3 dedicated appointment slots daily for 111 and the out of hours GP services to book patients into. There were systems and processes in place to ensure appropriate handover information was given to the practice in relation to patients seen in out of hours settings. A dedicated phone line was available for urgent cases to be communicated efficiently. • The practice had systems in place to alert staff for prioritising appointments for vulnerable 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 responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	85.5%	N/A	49.6%	Significant variation (positive)

The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	70.0%	60.5%	54.4%	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 (01/01/2023 to 30/04/2023)	53.4%	56.8%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	75.4%	75.2%	72.0%	No statistical variation

Any additional evidence or comments

- The practice had implemented a new cloud-based telephone system in 2022. Patients could be transferred across the partnership practices in contingency and there was an automated call back function to prevent patients waiting in a queue. The practice had oversight of telephone audit data including key performance indicators such as total inbound calls, call waiting times and call abandonments (an abandoned call is an inbound call that does not get answered, a high abandonment rate can indicate safety concerns).
- We saw evidence of telephone audit data from September 2023 that showed a total of 603,869 inbound calls. There was a total of 37,452 calls abandoned, 6.2%. The average waiting time was 17 seconds per call. There was a process in place for further administrative support to meet demand should inbound telephone calls reached 5 and over.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care

Complaints	
Number of complaints received in the last year.	4
Number of complaints we examined.	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice manager held oversight for investigation and responding to complaints received. The practice had a complaints policy in place which included a complaints response timeframe of three 	

working day initial acknowledgement with a thirty-day investigation timeframe before a further acknowledgment letter was required for extension.

- At the time of inspection, we identified there were 4 complaints the practice received in the last 12 months and that they were all resolved. We reviewed 3 complaints and found that the investigation and acknowledgement letters were in line with the practice's complaints policy.
- The practice had an open and transparent approach to complaints. Investigations were conducted by relevant staff. Outcomes from investigations were shared at team meetings and with individual staff as needed. Informal complaints were resolved with patients at the time of raising.

Example(s) of learning from complaints.

Complaint	Specific action taken
There was an issue with the clarity of verbal treatment discussed by a clinician to a patient.	<ul style="list-style-type: none"> • The practice had reviewed consultation record and processes. Learning was shared with staff to reduce the risk of reoccurrence. The complaint was responded to appropriately in line with practice policy.
Aggressive behaviour was shown by a patient.	<ul style="list-style-type: none"> • The practice had updated the zero-tolerance policy to include guidance on warnings and escalation processes. Signage was implemented in the practice waiting areas.
There was an issue with the context of clinical information on a patient referral resulting in secondary care delays.	<ul style="list-style-type: none"> • The practice had investigated the root cause of the delay of the referral. This was due to misinterpretation of records from the secondary care provider. The practice complied with the duty of candour and was open and honest with the response to the patient. The patient was subsequently re-referred as a priority. Learning was shared through a practice meeting to ensure safety netting administrative processes were followed to minimise the risk of reoccurrence.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y

There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The partners met monthly to monitor actions against their business strategy plan. There was a quality improvement plan, which was last reviewed in September 2023, identified objectives and areas where additional support and resources was required to improve and sustain services. Risks were reviewed and actions were updated accordingly. There was an action plan in place to address any shortfalls in performance. For example, the practice was working with the partnership primary care network (PCN) to streamline processes when receiving and filing results within the NHS app. There were plans to create more system templates to allow for a consistent approach to patient communication. • The practice had a succession plan in place to replace those who were likely to retire and planned to support staff to encourage leadership in key areas in the practice. • The nursing team was given additional training opportunities to lead in specialist areas such as; leg ulcers, diabetes, asthma, long-term conditions and childhood immunisations. 	

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> <ul style="list-style-type: none"> • There was a mission statement displayed on the practice's website which staff were aware of. Staff said they were proud to work for the practice and there was support available to carry out their roles. • The practice had a set of values developed in collaboration with staff underpinning the overall mission statement. 	

Culture

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

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

The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The incident reporting system complied with the requirements of the duty of candour. • Staff were able to speak up openly if they had any concerns and the working environment was friendly and supportive. Staff had access to a freedom to speak up guardian and a mental health first aider. • The practice had a whistleblowing procedure available for staff to access electronically and in paper format at the practice. 	

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

Source	Feedback
17 CQC staff feedback forms	<p>We distributed staff questionnaires to practice staff. Common themes from responses included:</p> <ul style="list-style-type: none"> • Staff worked in a friendly and supportive environment. Practice management were open, transparent and approachable. • The provider acted on staff feedback. Views and opinions were valued. • Extra clinical and non-clinical staff employed would help reduce demand and workload whilst helping improve capacity to meet patient expectations.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, not all systems had been fully embedded.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There were systems in place to ensure patient care pathways and protocols were followed in line with national guidelines. • We conducted clinical records searches and found that there was a consistent approach to managing safety alerts. • There was oversight in the system to manage mandatory training compliance, of which all staff had completed mandatory training modules. 	

- We identified issues at the inspection not recognised and actioned by the practice’s own governance systems. For example, we found that the practice was unable to demonstrate the prescribing competence of non-medical prescribers through a regular review of their prescribing practice supported by clinical supervision or peer review. We also identified that medicines had not always been risk assessed to ensure appropriate medicines were included or not included in stock. The provider had an action plan in place and provided evidence of remedial actions taken after the inspection to improve aspects to support good governance, such as developing individual risk assessments, updating medicine management policies as well as reviewed health and safety in the premises to include the update of safety signage where equipment and emergency oxygen was kept.
- There was adequate oversight to ensure staff had the correct updated information required to deliver safe care and treatment. For example, clinical coding and patient summarising (the process of extracting and coding patient health records) was kept up to date to prevent backlogs and delays to treatment.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was a business continuity policy in place that was last reviewed in July 2023. This gave guidance to staff for the preparation of major incidents. Impact of care was assessed and involved external stakeholders, for example, the other practices within Wyvern Health Partnership and the local care home attached to the practice. • The practice had a system in place to liaise with specialists when managing patients for specific conditions such as dermatology or musculoskeletal conditions, including assurance checks to ensure referrals were processed and followed-up. 	

Appropriate and accurate information

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

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

Explanation of any answers and additional evidence:

- The practice had not needed to make any statutory notifications to relevant organisations such as the Care Quality Commission (CQC) or National Health Service England (NHSE) within the last 12 months. However, members of the leadership team were aware of their responsibilities to do so if a notification was required.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Patient data and information was stored securely in line with digital security standards with relevant information was made available for patients to access in line with privacy, consent notices and general data protection regulations. Information was available for patients on how their data was used, choices regarding consent and how to protect their online data through notices within the practice, practice registration forms or online via the practice website. 	

Engagement with patients, the public, staff and external partners

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

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

Explanation of any answers and additional evidence:

- The practice formed a Wyvern Health Primary Care Network (PCN) Patient Participation Group (PPG) in January 2023, which met with key staff members at each of the 5 partnership practices, quarterly. Areas discussed included, PCN wide projects and initiatives; patient access to community services; staffing capacity and patient feedback.
- Oversight of patient feedback was managed effectively. Patient feedback and views on treatment and care were obtained through surveys and 'Friends and Family Test feedback'. We saw themes particularly reflected patient access and person-centred care were positive. We saw evidence of actions taken in response to patient feedback such as a change to the extended access arrangements to allow for patient appointments to commence earlier in the mornings during some weekdays.
- The practice involved staff with improving services. Staff feedback was obtained during appraisals and staff meetings. The practice had implemented a staff newsletter and noticeboard to showcase updates to practice procedures and human resourcing supporting information. The PCN had plans to implement an annual staff feedback survey and form a staff forum to further embed a positive working culture across the partnership.
- Practices within the PCN partnership shared resources such as staff, training and system wide group policies and procedures. The PCN partnership had been registered as a training network and at the time of inspection had secured places for health care assistant (HCA) staff to take part in the trainee nurse associate (TNA) program as part of continuing professional development (CPD).

Feedback from Patient Participation Group.

Feedback

- At this inspection, we obtained feedback from PPG members who highlighted that there had been engagement meetings between key members of the 5 partnership practices. There was ongoing work to improve patient communication across the partnership. We saw evidence of examples such as a Wyvern Health patient survey that was developed and the implementation of a Wyvern Health Partnership patient newsletter which highlighted key service updates of member practices.

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

Explanation of any answers and additional evidence:

- The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, there was a clear plan for conducting clinical and non-clinical audits, with dedicated leads for audit areas. Outcomes and learning were shared with staff.
- The practice had received funding in October 2023 from the Swindon Integrated Care Alliance for improving health inequalities amongst the practice population. We saw evidence of resource planning

focusing on early cancer diagnosis by increasing education and awareness of bowel, cervical and breast screening in areas of Black, Asian and Minority Ethnic (BAME), other languages (not including English), Learning Disability patients, visually impaired and LGBTQ+ communities.

There were plans in place to further develop a separate recall system across the 5 partnership practices to identify transgender patients who are eligible for cancer screening.

Resourcing planning to also include the use of clinical data intelligence to identify patients who have Chronic Respiratory Disease including Chronic Obstructive Pulmonary Disease (COPD) to increase the uptake of vaccination clinics to reduce emergency hospital admissions.

Actions and outcomes from the project were not available at the time of inspection.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a “z-score” (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice’s data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice’s data looks similar across two indicators, but they are in different variation bands. The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of 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 those aged 25 to 49, and within 5.5 years for those 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.