

Inspection Evidence Table

Middlewich Road Surgery

(1-554713055)

Inspection Date: 22 November 2023

Overall rating: Good

Context

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the sixth lowest decile (6 of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 97.6% White, 1.1% Asian, 0.9% Mixed, 0.2% Black, 0.1% Other.

The practice had experienced recruitment issues and had filled a range of vacancies in the months prior to the inspection. However, recruitment for non-clinical and nursing staff was ongoing. Patient feedback regarding issues with access to the service had led to a review and ongoing monitoring of the appointment booking system and access to the service.

Safe

Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However, non-clinical staff were not all trained to the appropriate level.

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.	Partial
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.	Partial
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> <p>Safeguarding information supported staff to manage any safeguarding concerns. The safeguarding policy did not accurately outline the training levels required for staff. Clinical staff had completed safeguarding training to appropriate levels. However, all non-clinical staff had completed level 1 safeguarding children training. As these staff members had contact with children as part of their role they should have been trained to level 2 in accordance with the safeguarding children and young people intercollegiate guidance. The provider informed us that the training requirements would be updated in the policy and training documents and that staff would complete the appropriate levels of training.</p> <p>The provider had a policy for all new staff to have Disclosure and Barring Service (DBS) checks when recruited. All clinical staff had these checks completed. All non-clinical staff had not had DBS checks completed but this had been risk assessed. The provider informed us during the inspection that following review all staff working at the practice would have a DBS check completed to comply with practice policies.</p> <p>Information was shared appropriately, this included regular discussions during practice meetings and with external teams such as health visiting teams and out of hours services.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed 4 staff personnel files and saw that the required information was obtained upon recruitment.</p>	

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: October 2023	
There was a fire procedure.	Y
Date of fire risk assessment: November 2023	
Actions from fire risk assessment were identified and completed.	Y

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.	Partial
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 17 January 2023	
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
Explanation of any answers and additional evidence: The most recent infection prevention and control audit conducted showed the practice had attained 97.9% compliance with standards with all action taken appropriately. Not all staff had completed infection prevention and control training at the time of the inspection.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence: In the event of absence, staff covered from within the team. Holidays were planned and clinical staff covered in their absence by other employed clinicians or locum staff as required. Staff knew the processes for managing emergencies. They were able to signpost to urgent and emergency services or get help from clinicians for deteriorating patients. Not all staff had completed sepsis training, but information was available to support staff with awareness of the signs and protocols to follow. There was a vacancy for an advanced nurse practitioner with regular locum staff covering at the time of the inspection. There were also vacancies for reception staff which were being advertised at the time of the	

inspection. Staff across the team worked additional hours to ensure essential work was covered and did not report that these hours were excessive at the time of the inspection.

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> <p>The clinical searches conducted identified that assessments and reviews were completed in a timely manner with high quality documentation in patient care records.</p> <p>The provider had a system to ensure the appropriate action had taken place for test results and referrals.</p>	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	1.06	0.94	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)	4.5%	6.9%	7.8%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r	4.01	4.92	5.24	Variation (positive)

capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	164.6‰	150.0‰	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)	0.41	0.47	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	8.0‰	6.8‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
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.	N
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.	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>As part of our inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. These searches were visible to the practice. We found that overall, the quality of documentation and monitoring was good. However:</p> <p>There were 134 patients aged over 70 years who were prescribed non-steroid anti-inflammatory drugs (NSAID) or antiplatelet medicines. Of these, 29 were not prescribed an additional medicine to reduce the risks of complications. We sampled 5 patient records and found that whilst there were no factors identified that would indicate high risk, we recommended that all these patients were reviewed to ensure safe prescribing of medicines.</p> <p>We looked at a sample of 5 Patient Group Directions and found 1 had not been appropriately authorised to indicate the nursing team administering were competent to do so.</p> <p>There was one non-medical prescriber working at the practice who was employed by another local provider and told us they accessed supervision and review of prescribing with their employing practice. There were not yet formal processes in place to ensure the prescribing competence of non-medical prescribers. The provider told us action would be taken to address this.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	12
Number of events that required action:	12
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us they were encouraged to raise incidents and concerns, knew the processes for how to do this and were well supported when they did. Incidents were recorded, investigated, and responded to with escalation to a significant event where appropriate. Discussion of significant events and incidents including the learning and any action required took place in regular practice meetings.</p>	

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

Event	Specific action taken
Prescription issued with the incorrect dose.	Error identified prior to collection of medication, amendments made to prescription and reissued.
Prescription changes requested by specialist service not actioned.	Communication details updated to a central address.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider held a record of safety alerts and action taken. The provider was unable to demonstrate that all relevant historic safety alerts had been responded to. We saw that some patients were prescribed medicines that had risks associated without clear documentation in their records to indicate this had been identified and the risk discussed with the patient. The provider informed us that they were taking action to address this and improve the system for managing historic safety alerts.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>The service used a coding system to indicate when follow up reviews were required for patients with long term conditions and when medication reviews were required.</p>	

Effective care for the practice population

Findings

- 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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients with long term conditions were checked to ensure the required assessment and reviews were taking place. These searches are visible to the practice. The records we examined provided evidence that overall patients with long term conditions had been monitored and reviewed appropriately.

We identified 3 patients as having potential missed diagnosis of diabetes. We reviewed all of these patient records and for 1 of these did not see evidence of coding in place in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. The provider took immediate action by calling them in for follow up review.

We identified 17 patients as having potential missed diagnosis of chronic kidney disease. We reviewed 2 patient records and identified that whilst their condition was being managed appropriately some action was required to ensure accurate information was on their patient record to ensure appropriate ongoing monitoring took place. The provider took immediate action to resolve the issue identified.

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 for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	76	76	100.0%	Met 95% WHO based target
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)	74	76	97.4%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	75	76	98.7%	Met 95% WHO based target
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)	75	76	98.7%	Met 95% WHO based target

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)	58	63	92.1%	Met 90% minimum
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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 service had met the 95% World Health Organisation target for childhood vaccination in 4 of the 5 target areas. They had met the 90% minimum target for the other 1 area. The provider told us they encouraged uptake by calling families to attend, using the messaging system, reminding opportunistically, and providing information about the benefits of immunisations.

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)	61.2%	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)	64.8%	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)	74.0%	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)	54.5%	57.3%	54.9%	No statistical variation

Any additional evidence or comments
The service was below the 80% uptake for cervical screening target. Initiatives were in place to help increase uptake, for example, providing information to patients about the benefits of screening and appointments with clinicians available to pre book and attend at short notice. Unvalidated data for October 2023 provided by the practice indicated that the target had been met.

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. However, there was no planned audit programme in place.

	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
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: The provider did not provide evidence of a planned audit programme to work towards continuous improvement. However, we saw they had completed a range of audits where we saw examples of improvements as a result. This included a review of antibiotics for sinusitis that informed the practice of considerations with regards presenting symptoms and prescribing. An audit was completed to identify patients at risk of acute kidney injury due to medicines prescribed who were provided with information and reviewed. Other audits included: <ul style="list-style-type: none">• Optimisation of paracetamol dosing.• Infection control.• Medicines management.	

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, there were some gaps with completion of training, appraisals and 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.	Partial
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
Explanation of any answers and additional evidence:	

Staff provided feedback that they were encouraged with development and felt well supported in their roles. However, we found that some staff were not up to date with all mandatory training and that not all required training was included as requirements.

There was an appraisal system in place. We found that the majority of non-clinical staff had been due for their appraisal in September. The provider informed that these had not taken place due to staffing levels and requiring to prioritise workload at this time. They planned to schedule them at the earliest opportunity.

Clinical pharmacists worked at the practice but were employed by another local provider. There were not yet formal processes in place to assure the competence of these staff members. The provider informed us that they would address this.

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:	
Patient information was shared with external providers to support their care such as with out of hours services and health visitors.	

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:</p> <p>Patients were referred to services to support them with their health and social needs. This included a social prescribing service to support patients by connecting them to activities, groups and services in their community to meet the practical, social and emotional needs that affected their health and well-being.</p> <p>Patients were signposted to services to help them manage health conditions.</p> <p>Information was available at the practice about lifestyle choices and health improvement.</p>

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance. However, some improvements were required with documentation.

	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.	Partial
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</p> <p>We looked at 5 patient records to review documentation of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Alerts and key information were on patient records to indicate a DNACPR decision was in place. We saw that this had been shared with relevant agencies. However, not all information regarding the assessments for the decisions were always documented fully. The form documenting the decision was not on 2 patient records where the DNACPR decision was made in hospital.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had participated in a quality improvement programme which supported to develop plans to improve access which were in progress at the time of the inspection.</p> <p>The provider had reviewed the types of appointments available and how patients accessed the service. Routine appointments were available to pre-book up to 2 weeks in advance. Urgent appointments were available on the day following triage by clinicians. Recruitment and review of systems had taken place to increase capacity across the teams to meet the needs of patients. For example, the provider had identified times of significantly higher demand for appointments and increased clinical capacity at these times.</p> <p>The service utilised appointment availability at locations across the primary care network. They were also working to educate patients regarding the types of appointments and the range of clinicians available including discussions with staff at the time of booking and information leaflets and on the practice websites.</p> <p>Following review of patient feedback and the service provision, the length of time of pre-bookable appointments had been changed to 15 minutes to manage the increasing complexity of patients' health needs. The service had increased online digital appointments and was promoting this service.</p> <p>There were systems to ensure patients who should be prioritised could access appointments. This included young children and babies, vulnerable people and those who had been unsuccessful in getting appointments on successive days.</p> <p>Staff had completed care navigation training to effectively signpost patients to appropriate appointments. Staff had been trained to signpost patients to alternative services where appropriate to make more effective use of resources.</p> <p>Extended hours appointments were offered for those who required appointments outside of regular practice opening hours. Appointment times were adjusted for patients who required longer, for example those with a learning disability.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 8pm
Tuesday	8am – 6:30pm
Wednesday	8am – 6:30pm
Thursday	8am – 6:30pm
Friday	8am – 6:30pm
Appointments available:	

Monday	8am - 8pm
Tuesday	8am – 6:30pm
Wednesday	8am – 6:30pm
Thursday	8am – 6:30pm
Friday	8am – 6:30pm
Saturday (2 per month)	9am – 12 midday

Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a Primary Care Network. Appointments were available 2 Saturdays per month 9am until 12 midday. The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- Patients had access to a care co-ordinator and social prescriber through the primary care network. This service helped patients around finances, communication, personal, social and housing concerns or needs.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to 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>Feedback was obtained from patients through friends and family results, inhouse patient survey and audits of access.</p> <p>The provider was aware of the challenges with access and continuing to review the appointments available for patients. Additional clinicians had recently been employed and information was being provided to inform patients of their skills to promote appointments.</p> <p>Following initial contact, a GP triaged patient appointments to ensure clinical urgency was met. At the time of the inspection the provider had a plan to change the telephone system to improve the experience of making an appointment at the service and increase capacity. Patients had access to an e-consult service where clinicians made triage decisions prior to booking the most suitable appointment.</p> <p>We saw pre-bookable appointments were available with a range of clinicians and could be face-to-face or by telephone depending on the preference of patients. Additional appointments with a range of clinicians were provided by the Primary Care Network at other locations in the area.</p>

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	52.8%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	59.9%	60.7%	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)	48.2%	56.0%	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)	72.2%	76.6%	72.0%	No statistical variation

Any additional evidence or comments

Patient feedback from the national GP patient survey 2023 indicated levels of patient satisfaction comparable to local and national averages. Whilst 3 of the questions on the survey indicated similar or slightly worse data

than the previous survey in 2022, patients who responded positively to the overall experience of making an appointment had increased by 7%.

Family and Friends test results for August to October 2023 indicated 92% of patients (of 443 who participated) would be likely or extremely likely to recommend the service.

The provider conducted their own patient survey in March 2023 with 500 patients who had attended for appointments completing during the month. The results of this survey showed 86% of patients indicated they had found it easy to get through to the surgery by phone, 75% of patients responded that they were satisfied with the appointment offered and 60% responded they were happy with the experience of making an appointment. However, only 41% of patients responded that they were satisfied with the GP appointment times available.

The provider had reviewed feedback, devised an action plan and was working with the primary care network to try to improve access to the service. Recruitment and review of systems had taken place to increase capacity across the teams to meet the needs of patients. For example, the provider had identified times of significantly higher demand for appointments and increased clinical capacity at these times. Extended hours appointments were available at the practice and at other locations in the primary care network.

To address patient dissatisfaction with telephone access the provider had displayed information to inform patients of the best times to call, staff were managed to prioritise answering calls at busier times and audited calls received. There were plans to change the telephone systems to support the plans to improve access.

Source	Feedback
NHS.uk website (formerly NHS Choices)	There was 1 recent review on the NHS.uk website. The feedback was negative regarding issues with prescription issues and waiting time for an appointment.
Patient feedback directly to CQC.	There were low levels of patient feedback received directly to CQC and the feedback received was positive.
Healthwatch	There were 3 positive comments recorded by Healthwatch in the 12 months prior to the inspection.

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.	7
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y

There was evidence that complaints were used to drive continuous improvement.	Y
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Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint regarding travel vaccinations appointment availability.	Patient information updated to clarify processes for the service.
Complaint regarding attitude of reception staff.	Recording of conversation reviewed, information provided for complainant, processes and training regarding communication updated with staff member.

Well-led

Rating: Requires improvement

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>The provider of this service was a partnership with 4 GP partners. Staff told us they felt well supported by the team and that there was visible and approachable leadership.</p> <p>One of the main challenges to the service were recruitment and capacity. Staffing levels impacted upon workload and leaders were aware of the issues with sustainability of the increased pressures. Action was being taken with regards ongoing recruitment and monitoring the priorities for staff to ensure risks to the service were mitigated. Whilst we did not see patient care had been impacted directly, we did see that completion of staff training and appraisals had been.</p> <p>The provider was responsive to challenges and concerns presented to the service including action points identified at the inspection which were addressed at the time.</p>	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: Staff told us they were aware of the plans for the service and that they had opportunities to provide feedback and ideas which were listened to and actioned when possible by the management team. Staff meetings were taking place regularly where updates and information were shared. Patient feedback had been reviewed and action plans were in progress to address the improvements identified.	

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: We received positive feedback from staff about the culture at the practice. Staff told us they were encouraged to raise any concerns and when they did were confident that appropriate action would be taken and that they were supported with policies and systems in their roles.	

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

Source	Feedback
Staff interviews and feedback forms	Staff told us they felt well supported and valued by leaders and their team, that communications were good, and all worked towards ensuring patients received high quality care.

Governance arrangements

Improvements were required to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were some gaps and oversights that indicated not all governance systems were effective. We reviewed authorisations of patient group directions and found that of 5 reviewed, 1 had not been appropriately authorised. Documentation for DNACPR decisions had not been fully completed in all patient records we reviewed. The safeguarding children policy did not accurately detail the required levels of training required for staff and 3 of 9 non-clinical staff had not completed Level 2 training. Not all staff were up to date with mandatory training.</p> <p>Analysis of incidents and complaints and review of patient and staff feedback demonstrated embedded quality improvement processes.</p>	

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.	Partial
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: The provider had an ongoing recruitment plan to employ staff to work at the practice. Risks had been identified with staffing levels and were being monitored and managed by the provider. Quality improvement work was undertaken including medicine prescribing audits. However, a written programme of quality improvement was not in place to maintain and improve the service provided.	

Appropriate and accurate information

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

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

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y

Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

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.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider was aware of the improvements required to improve patient feedback that had been received with regards access. They had participated in a programme providing support for practices and developed plans to improve access which were in progress at the time of the inspection.</p> <p>Some patients informed the practice that they wanted more availability for online appointments. The provider was increasing access to the online booking facility and encouraging patients to activate this to enable use. Communications had been sent out to patients with regards booking information and timings for booking appointments by telephone to try to manage capacity for telephone access. Plans were in place for changing the telephone system.</p> <p>There was not an active Patient Participation Group (PPG) at the time of the inspection. The provider was actively encouraging patients to join as members by advertising for patients to join the group.</p> <p>Staff told us the leadership team listened to their views and concerns about the service and made improvements as a result.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y

Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider supported and encouraged improvements through protected learning time for staff, a range of audits, incident, and complaints analysis.</p>	

Examples of continuous learning and improvement
<p>The practice worked with the other practices in the primary care network and associated practices to develop services and improve outcomes for patients.</p> <p>The practice had participated in a programme for support with development and improvement. Individual staff had participated in programmes including career development and leadership, teaching mentorships. They were working with the primary care network quality improvement programme focussed on staff wellbeing improvements.</p>

Notes: CQC GP Insight

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

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

The following language is used for showing variation:

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

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

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