

# Care Quality Commission

## Inspection Evidence Table

**Dr Jerome Kaine Ikwueke (1-496222451)**

**Inspection date: 5 September 2022 (on site) and 20 September 2022 (remote)**

**Date of data download: 24 August 2022**

## Overall rating: Good

- Leaders had robustly responded to the concerns identified at our July 2021 inspection and had achieved compliance with the relevant Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Action had been taken since our last inspection, such that the practice's monitoring systems now kept patients safe in relation to the use of high-risk medicines.
- We noted there were now adequate systems in place to manage risks associated with emergency situations.
- We noted that when things went wrong, there were now systems in place to review, investigate and learn.
- We noted the practice now had appropriate systems in place to act on safety alerts.
- Clinical searches confirmed that the practice's management of long-term conditions now reflected current evidence-based guidance, standards and best practice.
- We noted that complaints were now handled appropriately - including timely acknowledgment, response and appropriate systems for learning from complaints.
- Clinical audits were carried out and all relevant staff were involved. There was also participation in relevant local audits (such as prescribing audits).
- Patient feedback was generally above local and national averages regarding phone and appointments access. Patients fed back that they could access the right care at the right time.
- Governance arrangements now supported the delivery of high-quality and patient centred care (for example regarding staff induction arrangements, significant incident reporting, safety alerts and complaints management). We noted systems and arrangements were in place to ensure these governance improvements were sustained.

## Safe

## Rating: Good

- Action had been taken since our last inspection such that the practice's monitoring systems now kept patients safe in relation to the use of high-risk medicines.
- We noted that when things went wrong, there were now systems in place to review, investigate and learn.
- We noted the practice now had appropriate systems in place to act on safety alerts.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: Action had been taken since our July 2021 inspection, such that DBS checks were now on file for the practice's two part time locum nurses.	

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:	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 11.10.21	Y
There was a fire procedure. Date of fire risk assessment: 11.10.21	Y
Actions from fire risk assessment were identified and completed.	N/A No risks identified
Explanation of any answers and additional evidence:	

### 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. Date of last infection prevention and control audit: 25.7.22	Y
The practice had acted on any issues identified in infection prevention and control audits.	N/A No risks identified
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

## 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:

### Medical Emergencies

When we inspected in July 2021, we could not be assured staff understood their responsibilities in the event of a medical emergency. For example, we did not see evidence of a written emergency medicines protocol advising staff of the location of emergency medicines and the required frequency of periodic checks. Shortly after our inspection we were sent a copy of the provider's new emergency medicines protocol and when we inspected on 14 March 2022, we confirmed that staff were operating in accordance with this protocol. For example, staff showed us where emergency medicines were located and we also saw that, in accordance with the protocol, staff were undertaking periodic checks of the practice's emergency oxygen and defibrillator. We also noted that written risk assessments informed decisions not to carry certain emergency medicines.

At our 5 September 2022 inspection, we saw that these arrangements continued to be in place and supported staff in responding to medical emergencies.

### Induction Systems

When we inspected in July 2021, the provider did not operate effective staff induction systems - as evidenced by an absence of induction documents for some staff and a lack of clarity regarding whether the referenced practice induction protocol was current. We asked the provider to take action and on 14 March 2022 we noted signed induction documents were on file for the two staff records we reviewed. A new, version controlled induction protocol had also been introduced and the practice's GP locum Induction Pack was located on the practice's shared drive, to ensure that locum GPs were working to the latest practice protocols.

At our 5 September 2022 inspection, we noted there had not been any staff recruitment or subsequent staff induction activity since 14 March 2022.

## 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
Explanation of any answers and additional evidence: Our remote clinical searches provided assurance that staff had the information they needed to deliver safe care and treatment (for example confirming that individual care records were written in line with current guidance and that there was a documented, timely approach to the management of test results).	

## Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.48	0.56	0.79	Variation (positive)
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). (01/04/2021 to 31/03/2022) (NHSBSA)	7.7%	10.2%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	4.69	5.74	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	101.2‰	60.0‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.23	0.58	0.60	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	6.7‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

Medicines management	Y/N/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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. <sup>1</sup>	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. <sup>2</sup>	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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence, including from clinical searches.	
<u>Process for monitoring patients' health in relation to the use of medicines (including high risk medicines)</u>	
<p>When we inspected in July 2021, our remote clinical records searches and individual records reviews highlighted instances where monitoring systems did not always keep patients safe in relation to the use of high risk medicines. We asked the provider to take action.</p> <p>When we re-inspected on 14 March 2022, we noted that the practice had introduced a high-risk medication review system and that its high-risk medication policy had been updated. We also noted that high-risk medication monitoring was now a standard agenda item at clinical meetings. Consequently, our remote clinical records searches did not identify any monitoring concerns. We were also satisfied appropriate action had been taken in response to patient specific monitoring concerns identified in July 2021.</p>	

Medicines management	Y/N/Partial
<p>At the 5 September 2022 inspection, our remote clinical records searches did not identify monitoring concerns in relation to the use of high risk medicines. We were assured that monitoring arrangements continued to keep patients safe.</p> <p><u>Patient Group Directions</u></p> <p>When we inspected in September 2022, we noted action had been taken such that Patient Group Directions were now signed and counter signed with the actual calendar date (as opposed to the July 2021 practice of only specifying the month and year).</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 since March 2022:	16
Number of events that required action:	8
Explanation of any answers and additional evidence:  When we inspected in July 2021, we noted that where things went wrong, the approach to reviewing and investigating causes was insufficient. Clinical and non-clinical team meetings did not routinely discuss significant events and it was therefore unclear how learning took place and what actions, if any, had taken place in order to improve safety.  We asked the provider to act and re-inspected on 14 March 2022. We noted the provider had reviewed its significant events policy and that this now mandated discussion of significant events at the practice's weekly clinical meetings. Records confirmed this was happening and we also saw evidence of staff discussion of the operation of the protocol.  At our 5 September 2022 inspection we noted the practice's significant incident reporting systems supported staff in sharing learning from incidents and in taking action as necessary in order to maintain or improve patient safety.	

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

Event	Specific action taken
Concern raised by practice nurse regarding a potential increase in recorded fridge temperature	Lead GP investigated incident and provided assurance that the temperature was still within the required temperature range. Incident was discussed at team meeting (including a refresher discussion on temperature recording protocols).

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>When we inspected in July 2021, we found the provider lacked an effective system to act on Medicines and Healthcare products Regulatory Agency (MHRA) patient safety alerts. We received conflicting information from staff members regarding who was responsible for receiving and disseminating patient safety alerts and were also told that the provider did not have its own protocol for disseminating and acting on alerts (having had adopted the local Primary Care Network's Safety Alert Protocol). Consequently, our clinical records searches highlighted instances where the provider had not taken appropriate action in response to safety alerts.</p> <p>Shortly after our inspection we were advised that a practice specific Safety Alert Protocol had been introduced and when we re-inspected on 14 March 2022 we noted that the practice's clinical pharmacist had introduced a monthly drugs alerts newsletter and that safety alerts was now a standing agenda item at clinical meetings. When we ran our remote clinical searches, they highlighted that appropriate action had been taken in relation to alerting patients to risks (including those patients identified as being at risk in July 2021).</p> <p>At our 5 September 2022 inspection, CQC remote clinical searches highlighted that the practice continued to take appropriate action, as necessary, in relation to alerting patients to risks. We were assured the practice had appropriate systems in place to act on safety alerts.</p>	

## Effective

## Rating: Good

- CQC remote clinical searches confirmed that the practice's management of long-term conditions now reflected current evidence-based guidance, standards and best practice.
- Clinical audits were carried out and all relevant staff were involved. There was also participation in relevant local audits (such as prescribing audits).
- Unverified practice data indicated that cervical screening and child immunisation uptake targets were being met.

*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. <sup>1</sup>	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence:	

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- When we inspected in July 2021 our remote searches of the practice's clinical records system highlighted instances where people from this population group were not receiving effective care or treatment. For example, instances of undiagnosed diabetes, outstanding annual asthma reviews and sub optimal care being provided for patients with hypertension. When we inspected again in March 2022, we saw evidence that monitoring arrangements had improved and that the patients we previously identified as not receiving effective care were now being appropriately monitored. At our September 2022 inspection, we undertook new searches to seek assurance regarding management of long-term conditions. For example:

A clinical search to identify patients who had had two or more raised HbA1c readings, indicating diabetes but without diabetes being coded, which did not identify any concerns.

A search run to identify patients with a missed diagnosis of Chronic Kidney Disease (indicated by an eGFR of less than 60 mL/min/1.73 m<sup>2</sup> and no diagnosis of Chronic Kidney Disease stage 3-5) which identified two patients (both considered to be low risk).

A search to identify patients with Chronic Kidney Disease who had not had a renal function test within the previous 9 months which identified four patients (the renal function monitoring for two of which was taking place in secondary care).

A search run to identify patients being prescribed thyroid hormone level medication in the absence of annual blood test monitoring, which identified one such patient (whose record confirmed that a blood test had recently been booked).

A search run to identify high risk patients whose latest HbA1c was more than 74mmol/l and who consequently had diabetic retinopathy (damage to the retina) which sought assurance that the progression of their disease to the point of diabetic retinopathy had been taken into account in the management of their condition. A patient records review of four of the twenty patients identified in this search confirmed that diabetic annual reviews and medication reviews had taken place in the last 12 months; and also that an HbA1c reading had been taken in the last 3 months.

A search undertaken to assess whether patients with Asthma who had had two or more courses of rescue steroids in the last 12 months had been reviewed within 7 days of an acute exacerbation of asthma. This search highlighted that a review within 7 days had not taken place for the 7 identified patients but this was considered low risk.

In the above isolated instances where concerns were identified, the provider agreed to act and contact patients as necessary. Overall, our search findings and patient record reviews provided assurance that monitoring arrangements for patients with long term conditions had greatly improved since our July 2021 inspection.

- 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	40	53	75.5%	Below 80% uptake
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	27	39	69.2%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	28	39	71.8%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	27	39	69.2%	Below 80% uptake
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	31	42	73.8%	Below 80% uptake

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

Any additional evidence or comments
<p>We were advised that local vaccine hesitancy had historically contributed to the practice's child immunisation rates but that the practice continued to explore how to improve performance (for example by reviewing its patient recall systems and by opportunistic discussion with parents). Unverified practice data indicated that child immunisations uptake ranged between 77% - 82%.</p>

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	66.1%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	58.6%	47.4%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	55.0%	57.2%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	83.3%	54.6%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
<p>Leaders had been aware of the practice's lower than average cervical screening uptake rate. They highlighted a range of activity (including additional improved patient recall and monitoring systems) aimed at improving performance.</p> <p>Unverified practice data indicated that as of 5 September 2022, 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) was respectively 82% and 87%.</p>

## Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

We saw evidence that the practice had undertaken two cycle clinical audits including an audit on the effect of the Covid-19 pandemic on referral patterns, an audit of two week wait cancer referrals and an audit assessing whether increases in knowledge via training courses had led to a reduction in referrals.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	



When we inspected in July 2021, the provider did not operate effective staff induction systems - as evidenced by an absence of induction documents for some staff and a lack of clarity regarding whether the referenced practice induction protocol was current.

We asked the provider to take action and at this inspection we noted a new, version controlled induction protocol had been introduced and that signed induction documents were on file for the two staff records we reviewed. We also noted the GP locum induction pack was located on the practice's shared drive to ensure that locums were working to the latest protocols.

## Coordinating care and treatment

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

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

## 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:  We were told that the practice's Social Prescriber appointments had recently been doubled, due to increased demand for advice regarding need extra support (for example regarding referrals to local benefit maximisation and carer support agencies).	

## 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. <sup>1</sup>	Y
Explanation of any answers and additional evidence Records confirmed that patients' views had been sought and respected and that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions had been made in line with relevant legislation. Records also confirmed that this information had been shared with relevant agencies.	

## 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:	

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	82.7%	83.4%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	80.4%	81.0%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	88.1%	91.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	76.4%	70.0%	72.4%	No statistical variation

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

## Involvement in decisions about care and treatment

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

	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: Easy read leaflets and pictorial materials were available in reception.	

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	81.1%	87.9%	89.9%	No statistical variation

## Any additional evidence or comments

Leaders told us they continued to explore ways of involving patients in decisions about their care and treatment.

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

Carers	Narrative
Percentage and number of carers identified.	3% (134)
How the practice supported carers (including young carers).	The provider offered a range of support to carers including documentation signposting carers to local care support agencies. The practice teams had also designated a 'Carer's Champion' to better support carers.
How the practice supported recently bereaved patients.	The practice sent sympathy cards to families and phoned them to offer condolences. Families were also offered an appointment if needed or were directed to third sector bereavement support organisations.

## Privacy and dignity

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

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

## Responsive

**Rating: Good**

- We noted that complaints were now handled appropriately - including timely acknowledgment, response and appropriate systems for learning from complaints.
- Patient feedback was generally above local and national averages regarding phone and appointments access. Patients fed back that they could access the right care at the right time.

### 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
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00am-6:30pm
Tuesday	08:00am-6:30pm
Wednesday	08:00am-6:30pm
Thursday	08:00am-6:30pm
Friday	08:00am-6:30pm
Appointments available:	
Monday	8:30am-7:00pm
Tuesday	8:30am-7:00pm

Wednesday	8:30am-7:00pm
Thursday	8:30am-7:00pm
Friday	8:30am-7:00pm
Extended hours appointments:	
Monday – Friday:	7:30pm-8:30pm
Saturday:	9:00am-5:00pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.
- 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 homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## Access to the service

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

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*



	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	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>A community Mental Health Nurse had recently been recruited: allowing the practice to offer one-hour long appointment to patients experiencing poor mental health. We were also told that the number of Social Prescriber appointments had recently been doubled, due to increased demand for advice (for example regarding referrals to local benefit maximisation and carer support agencies).</p>	

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	65.2%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	67.8%	54.3%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	69.8%	54.9%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	70.6%	68.5%	71.9%	No statistical variation

## Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received since our last inspection (14 March 2022)	2
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence:	
When we inspected in July 2021, we identified concerns regarding how complaints were logged, investigated and used to drive service improvement. When we re-inspected in March 2022, we noted that	

the practice's complaints policy had been reviewed and updated. A recently introduced complaints management spreadsheet allowed staff to log complaints and ensure that an acknowledgement letter was sent to the complainant within the required timescales.

When we inspected in September 2022, records confirmed that staff were acting in accordance with the practice's new complaints policy - for example by ensuring that written complaints responses included reference to the Parliamentary and Health Service Ombudsmen (should the complainant remain dissatisfied with the outcome). Records also confirmed that complaints management was now a standard agenda item at team meetings.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient unhappy at range of appointment types offered.	Practice website reviewed to ensure the range and scope of appointment types were clearly displayed.

## Well-led

## Rating: Good

- Leaders had robustly responded to the challenges presented by our July 2021 inspection findings and had delivered the necessary improvement actions. Systems were in place to ensure these improvements were sustained.
- Action had been taken since our last inspection such that governance arrangements now supported the delivery of high-quality care (for example regarding arrangements for staff induction, significant incident reporting, safety alerts and complaints management).
- Leaders had a clear vision for the practice and spoke positively about how staff now knew their role in achieving the practice's new vision and values.
- We saw evidence of systems and processes for learning, continuous improvement and innovation.

### 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
Explanation of any answers and additional evidence:	
When we inspected in July 2021, our findings indicated that leaders were out of touch with what was happening during day-to-day services; citing evidence including a lack of clinical oversight of safety alerts and a lack of administrative oversight of complaints.	
At this inspection, we saw evidence that leaders had robustly responded to the challenges presented by our July 2021 inspection findings and had identified the actions necessary to address these challenges. For example, we noted that a monitored action plan had been introduced to address the areas of concern identified at our July 2021 inspection. A new practice manager had recently been recruited to ensure the practice had the leadership capacity to sustain and monitor its improvements.	

## 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:  When we inspected in July 2021, although staff had a clear and shared vision to ensure that 'every patient mattered'; this was not underpinned by a credible strategy.  At this inspection we saw evidence that leaders had met with staff to agree a new mission statement and shared vision for the practice. Leaders spoke positively about how staff now knew their role in achieving the practice's new vision and values.	

## 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:	

Action had been taken since our July 2021 inspection, such that we now saw evidence that when things went wrong, complainants were given an apology and informed of any resulting action.

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

Source	Feedback
Reception staff	Spoke positively about how the new approach had allowed staff to share learning from significant events.

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
When we inspected in July 2021, governance arrangements for emergency medicines, safety alerts, significant incident reporting and high risk medicines monitoring placed patients at risk. We asked the provider to take action.	
When we inspected in March 2022, Leaders told us they had reviewed organisational governance and that staff roles and responsibilities had been clarified. We noted that a range of policies had been reviewed, updated and version controlled. Minutes of team meetings confirmed that the organisation was systematically reviewing its policies and procedures.	
When we inspected in September 2022, Leaders spoke positively about how the organisational governance review had helped determine individual responsibilities such as managing safety alerts and enable more effective performance monitoring. We were also told that a new practice manager had recently been recruited to ensure the practice had capacity to sustain its improvements. We noted that clinical governance oversight remained with lead GPs.	

## 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:	
Action had been taken since our July 2021 inspection, such that we now saw evidence of effective arrangements for identifying, managing and mitigating risks (for example regarding safety alerts, monitoring high risk medicines and staff induction arrangements).	

**The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic**

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

## 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:  Team meeting minutes evidenced use of data to monitor and improve performance; and use of performance information to hold staff to account.	

## 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
Explanation of any answers and additional evidence:	



## 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:  We saw evidence the practice initiated in house patient surveys and that results were discussed at clinical meetings.	

## 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:  We saw evidence the practice had undertaken two cycle clinical audits including an audit on the effect of Covid-19 pandemic on referral patterns, an audit of two week wait cancer referrals and an audit assessing whether increases in knowledge via training courses had led to a reduction in referrals.  We also saw that “Team Learning” was now a standard agenda item at clinical meetings and that topics included areas such as CQC clinical searches and child protection protocols. We saw evidence that audit findings were discussed at weekly clinical team meetings, as and when they became available.	

## Examples of continuous learning and improvement

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

### Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- **%** = per thousand.