

Inspection Evidence Table

The Corner Surgery

(1-544535446)

Inspection Date: 09/11/2023

Date of data download: 09/10/2023

Overall rating: Good

Context

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the fourth lowest decile (4 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 47.2% White, 33.5% Black, 7.7% Asian, 7.6% Mixed, and 4% Other.

The practice has more patients of working age compared with local and national averages, and fewer older people and young people.

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y

There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had designated safeguarding leads. All staff knew how to identify and report concerns. There were safeguarding policies that were accessible to staff and outlined who to contact if staff had concerns about a patient's welfare.</p> <p>We looked at the training records of 5 staff members and found all staff were up to date with safeguarding training appropriate to their role.</p> <p>There were notices in clinical rooms advising patients that chaperones were available. We saw staff who acted as chaperones were trained for the role.</p> <p>We saw staff had received Disclosure and Barring Service (DBS) checks (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).</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

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: April 2021	
There was a fire procedure.	Y
Date of fire risk assessment: August 2022	
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	

The provider had completed a health and safety risk assessment in April 2021. We saw actions identified by the risk assessment had been completed. This was completed by an external company and recommended to be completed within 2 years. The provider had scheduled a repeat assessment for November 2023.

Records showed that calibration testing of equipment and portable appliance testing (PAT) had been carried out within the last 12 months.

The provider had a fire evacuation plan and conducted fire drills. The most recent fire drill took place in March 2023. A fire risk assessment was scheduled for November 2023.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We looked at the training records of 5 staff members and saw they had received appropriate training in infection prevention and control (IPC).	

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.	N
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:	

There was an induction system for all new staff.

We looked at the training records of 5 members of staff and found all had completed training in basic life support and sepsis awareness.

We saw there was an inventory of emergency equipment and a checklist that showed regular monitoring took place. However, the defibrillator pads held at the practice were marked for training use only. After our inspection, the provider sent us evidence they had purchased 1 set of paediatric defibrillator pads and 2 sets of adult defibrillator pads suitable for use in emergency situations.

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:	
Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.	
There was a system to ensure referrals were managed in a timely manner.	

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)	0.51	0.69	0.91	Significant 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). (01/07/2022 to 30/06/2023) (NHSBSA)	5.7%	8.0%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	4.31	5.50	5.24	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	57.9‰	73.2‰	129.5‰	Tending towards variation (positive)
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)	0.14	0.36	0.54	Significant variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	3.2‰	4.8‰	6.8‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including 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.	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.	Partial
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The provider was able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required.</p> <p>There were 2 refrigerators in the practice used for the storage of vaccines. We found that the maximum temperature of one of the refrigerators was recorded as outside of the recommended range on 4 occasions in the previous 3 months. We did not find evidence of action taken by the provider when finding the temperatures to be out of range. The provider shared information from the data logger (a separate thermometer placed inside the refrigerator which records temperatures at set intervals) which showed that on 3 of the identified occasions the temperature was within the recommended range. On one occasion the temperature was outside the recommended range on the data logger as well as on the refrigerator's thermometer. The provider shared information about vaccine stability which showed that the vaccines would not have been affected by being at a higher temperature for the length of time recorded. The provider updated their policy so that staff would alert the duty doctor should the refrigerator record a temperature outside of the recommended range.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

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

Number of events that required action: 4	
<p>Explanation of any answers and additional evidence:</p> <p>We looked at 3 significant events that had been recorded in the last 12 months. We saw the events had been investigated, discussed in clinical meetings and action taken. We saw lessons learned were shared with staff.</p>	

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

Event	Specific action taken
Practice staff were absent from work, and the practice did not open at the specified time.	Incoming telephone calls were diverted to staff member's work phones so these could be answered at home. Staff were reminded to contact the duty doctor to inform them they are unwell and unable to work. The rota was checked and found that annual leave had been agreed without checking existing rotas. Processes were agreed to ensure staffing was checked before requests for leave were agreed.
There was a delay in sending an urgent referral.	The referral had been created but not sent. Staff received training in the correct process for sending and checking referrals. The patient received their referral.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The provider was unable to demonstrate that all relevant safety alerts had been responded to. We saw that patients remained on medicines without a record of a discussion of the risks associated with these medicines. We shared our findings with the provider. Following our inspection, the provider showed us evidence that all patients had been contacted to advise of the risks associated with their prescribed medicines.</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
Explanation of any answers and additional evidence: During our inspection, we completed a series of searches on the practice's clinical records system. These searches were completed with consent and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards, and evidence-based guidance. Our searches identified patients' needs were fully assessed and treatment was regularly reviewed and updated.	

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.
- 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

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

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)	53	56	94.6%	Met 90% minimum

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	50	64	78.1%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	52	64	81.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	49	64	76.6%	Below 80% uptake
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)	48	63	76.2%	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

Childhood immunisations were carried out in line with the national childhood vaccination programme.

NHS England results (published in March 2022) showed that uptake rates were higher than the World Health Organisation (WHO) minimum target of 90% for 1 indicator, and below 90% for 4 indicators.

The provider was aware of the published results and kept lists of patients who had declined or not attended vaccine appointments. The list was regularly reviewed and patients were contacted via letter, telephone and text message. Parents/carers were given the opportunity to ask questions and discuss concerns with clinical staff. Staff told us that often parents/carers would change their minds and agree to vaccinations following conversations with clinical staff. The provider identified that parents/carers were often hesitant for their child to receive 4 injections at 1 appointment (which is the procedure for the immunisations given on or after a child's first birthday), therefore the provider offered the opportunity for these immunisations to be given over 2 appointments.

The practice population included a number of patients who did not speak English, therefore translators were offered to ensure understanding of the immunisation process. The provider had identified that patients often spent periods of time in other countries so could be difficult to contact; and some patients had immunisation schedules that aligned with other countries rather than the UK.

The provider worked with other practices in the local area to share best practice, for example the introduction of links on text messages sent to patient/carers to allow direct bookings, without the need to call the practice. Evening and weekend appointments were offered via the local primary care network (PCN). The provider offered a home visiting service for patients who had previously failed to attend booked appointments. There were plans to introduce immunisation services at other locations in the local area.

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)	40.8%	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)	54.1%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (3/31/2023 to 3/31/2023) (UKHSA)	64.3%	N/A	80.0%	Below 70% uptake
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)	46.2%	50.7%	54.9%	No statistical variation

Any additional evidence or comments

Published results showed that the uptake for cervical cancer screening was below the 80% target for the national screening programme.

To increase uptake, the provider told us; patients could self-book for cervical screening; evening and weekend appointments were offered; staff sent recall messages to remind patients of the need to book an appointment; and opportunistic bookings were made, when patients attended the practice for other matters.

There was a designated member of staff whose role included review of the list of patients eligible for cervical cancer screening and sending of recall messages to patients. The provider had identified that many patients did not speak English as a first language and offered translation services to ensure patients' understanding of cervical cancer screening. The provider had also employed staff members who spoke languages commonly spoken by the practice population, including Spanish and Portuguese. The provider had spoken to patients who did not wish to take up cervical cancer screening in an attempt to understand the reasons for not attending. The provider found that some patients had screening with a doctor in another country or with an independent provider and had asked these patients to provide evidence of attendance elsewhere.

The provider had analysed the reasons why they may not be meeting cervical cancer screening targets. Unverified data provided by the practice showed patients aged 50 to 64 were more likely to attend appointments than patients aged 25 to 49. The provider concluded that there were issues with the practice recording medical history of new patients and the decision of patients who had opted out of screening tests. High pregnancy rates also contributed to ineligibility for cervical cancer screening.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>We saw evidence of 9 clinical audits and quality improvement projects that had been carried out in the last 2 years. For example, the provider had completed an audit on prescription of formula to babies with cow's milk allergy and had carried out quality improvement activities looking at ways to decrease the carbon footprint of the practice.</p>	

Effective staffing

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

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

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

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: The practice was a member of the Lambeth GP Food Co-op. Patients registered with the practice could attend a weekly session which provided a space locally for people to socialise and grow food together. The food was then sold to NHS hospitals and staff. Practice staff told us the project was popular with patients who may otherwise experience social isolation. The practice had a "parkrun champion" who attended local runs each week. This was advertised by the practice so patients wishing to join the runs could look out for this staff member for support. Health coaching was available through the local PCN. Patients could be referred to health and wellbeing coaches, the provider shared examples of where patients' health had improved as result of coaching sessions.	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: Our clinical review of notes where a DNACPR decision had been recorded, identified where possible the patients' views had been sought and respected. There were clearly documented reasons for the DNACPR decision which were not discriminatory nor based on assumptions about the person's quality of life.	

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
Explanation of any answers and additional evidence: The layout of the practice meant that the ground floor of the practice was accessible to people using wheelchairs or mobility scooters. There was a stairlift that could be used for access to the first floor, however staff told us that patients with limited mobility would usually be seen in consultation rooms on the ground floor. Toilets were accessible to people with limited mobility and there were designated baby changing facilities.	

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

Thursday	8am - 7pm
Friday	8am - 7pm

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.

Appointments were available until 7pm for school age children so that they did not need to miss school.

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.

Translation services were available for non-English speakers. A high number of patients registered with the practice spoke Spanish or Portuguese, the provider had employed staff members who were fluent in these languages.

The practice was a member of the Safe Surgeries initiative, which involved a declaration to ensure a lack of identification, proof of address or immigration status did not prevent patient registration. The provider acknowledged that administrative processes and lack of awareness among practice staff can put up barriers to access. Therefore, a training session was held to improve staff knowledge of migrant access to healthcare. Following the training session, the practice implemented a registration flowchart for staff guidance and incorporated Safe Surgeries practices into staff training. We saw information posters showing patients the practice was a safe surgery.

The practice was an Armed Forces veteran friendly accredited GP practice. There was a dedicated clinician with specialist knowledge of military related health conditions and patients were encouraged to let the practice know if they were a veteran.

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>Patients were able to contact the practice via telephone, in person, or online to make an appointment. All requests were triaged by the duty doctor and assigned to the most appropriate member of the clinical team. As well as GP and nurse appointments, patients could also be booked for appointments with the social prescriber or physiotherapist. Face to face and telephone appointments were available. Staff at the practice told us that telephone appointments were popular with the practice population which consisted of a higher number of working age adults than national averages.</p> <p>On the day of inspection, we looked at the practice's appointment system and found the next available face to face and telephone appointment with a GP was 9 November 2023 and the next face to face appointment with a nurse was 13 November 2023.</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)	59.3%	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)	56.2%	49.7%	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)	52.0%	50.0%	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)	62.8%	66.2%	72.0%	No statistical variation

Any additional evidence or comments

Results from the national GP patient survey published in April 2023 showed satisfaction scores in line with local and national averages. Performance across the 4 indicators had decreased since 2021 (although the number of respondents who were satisfied with their GP practice appointment times increased in 2022). This decrease was in line with local and national performance.

The provider had increased the number of reception staff to make it easier for patients to get through to someone at the practice on the telephone. The provider told us that the duty doctor system meant that patients did not have to call the practice first thing in the morning to get an appointment, as appointments could be allocated throughout the day. Same day GP appointments could always be offered. The triage system was explained to patients at registration.

The provider had an online system where patients could contact the practice, for example, for medicine requests. Requests received through the online portal were reviewed each day and allocated to the most appropriate member of staff to deal with them. Staff told us that by patients using the online portal for non-urgent requests, this made it easier for patients needing urgent appointments to get through to someone at their practice on the telephone.

Source	Feedback
NHS.uk website (formerly NHS Choices).	There was 1 review on the NHS website which was positive about the provider. Comments referred to responsive and accommodating staff.
Experience shared directly with CQC via our website.	There were 7 comments received directly by CQC. These were negative about the service. We heard there were occasions where the practice doors had been opened late and there were delays to responses to emails.
Interview with patients.	Patients spoke positively about access to the service. Comments referred to being able to make appointments that suited their needs. Patients also told us they were asked for their views and felt listened to by practice staff.

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.	15
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example of learning from complaints.

Complaint	Specific action taken
There was a delay to a patient receiving their prescription.	This incident was investigated and it was found an error was made by a member of staff, the patient also needed a monitoring test before the prescription could be completed. The patient received their test and prescription. This was discussed with the member of staff involved and learning was shared with the practice team.

Well-led

Rating: Good

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: The practice did not have a practice manager but was in the process of recruiting for this role. At the time of our inspection, practice manager duties were carried out by the lead GP.	

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 practices' vision, which was displayed in the practice.	

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
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed the training records of 5 staff members and found that all had completed training in equality and diversity.</p> <p>Staff told us they felt valued by the management team and the work environment was supportive and encouraged personal development.</p> <p>The provider had recently employed a wellbeing lead to support staff.</p>	

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

Source	Feedback
Staff interviews and feedback forms.	We received 9 staff feedback forms and spoke with 4 staff members at the practice. Feedback from staff was positive about the service provided to patients and support from the management team. Comments referred to patient-centred care, excellent triage system for patients, and support for good work-life balance for staff members.

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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y

Managing risks, issues and performance

There were processes for managing risks, issues and performance, however some improvements were needed.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: Our inspection identified that improvements were required in relation to management of risks relating to: <ul style="list-style-type: none">• The monitoring of emergency equipment.• The management of vaccine fridge temperatures.• The management of safety alerts. As a result of our inspection, action was taken in relation to all these risks.	

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.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an active patient participation group (PPG) who met with practice representatives approximately every 3 months. We saw examples of where the PPG had shared ideas for improvement and action the provider had taken in response to these. For example, patients had raised concerns that the screens on reception made it difficult for patients with hearing impairments to hear the receptionist. The practice was in the process of risk assessing the need for a screen to protect staff and patients and the need for accessibility for the practice population.</p>	

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:

Complaints and significant events were used to make improvements. We saw evidence that learning from complaints and significant events was shared with staff. Staff told us they attended meetings where learning was shared. Staff told us incidents were reviewed for learning purposes and not to place blame.

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.