

Inspection Evidence Table

Church View Medical Centre

(1-549721000)

Inspection Date: 19 & 23 October 2023

Date of data download: 06/10/2023

Overall rating: Good

Safe

Rating: Good

The practice was rated good for providing safe services because they were able to demonstrate that safety systems were in place and working effectively, antibiotic stewardship was effective, and patients had been proactively safeguarded from the risk of harm.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented, and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: The practice provided evidence that DBS checks were completed for all staff whose files we reviewed and that processes were in place to ensure that these were rechecked in line with the business priorities of the provider.	

Meeting minutes were supplied that demonstrated that multiple health care professionals were involved in delivering coordinated and person-centred care to patients.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an effective and comprehensive recruitment system, complete with effective oversight. We saw that staff were given generic inductions and were provided with more role specific training from senior colleagues. The practice also demonstrated that effective supervision of staff in specific roles was in place. For example, nurses and health care assistants (HCAs). These were formal and documented.</p> <p>Locum checks had been carried out on long-term locums when they started, and registration checks, and performance checks were conducted regularly by the management team to ensure that staff remained competent and appropriate to their roles.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: September 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: September 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider did not own the building from where they delivered services to their patient population. The provider gained assurances directly from the building owners to ensure the safety of their patients was being maintained, along with internal checks.</p> <p>External health and safety, along with fire risk assessments had been completed routinely in September 2023 and had identified no actions necessary to further mitigate risks in these areas. We saw that all necessary internal documentation was in place to support these. For example, fire drill logs (last completed in August 2023 – annually), alarm tests (weekly internally, along with an annual test, last completed in March 2023) and fire extinguisher check (July 2023) documentation were in place and up to date.</p> <p>We found that external portable appliance testing (PAT) and calibration checks had been completed routinely in September 2023, with no concerns identified. The provider also demonstrated that external asbestos testing had been completed in March 2023 and Legionella (water) testing had been completed in July 2023, indicating low risk. The actions that had been identified in this document had not yet been completed but were ongoing and the provider told us they would be completed before the assessment was scheduled to be redone in 2025. Regular testing of water temperatures and water outlets were conducted internally by the provider to ensure mitigation in the interim period.</p>	

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 (IPC).	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: September 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw that IPC audits had been completed in January, May and September of 2023 and no actions that needed addressing had been identified.</p> <p>We saw that cleaning staff were employed by the health centre management, not the practice, but the practice still had systems in place to ensure cleaning was maintained at a good standard. There were spot checks in place, allowing the practice management to feedback to the healthcare centre management, should cleaning be found to be not up to standard. We were told this was seldom the case.</p> <p>The practice also gained assurances that COSHH data sheets were in place for items kept on site for use of the cleaning staff. They also ensured that general risk assessment templates were in place, to be completed should the practice staff have a need to complete cleaning duties. Staff training of IPC was in place and staff we spoke with were able to articulate their role and procedures in place to support them.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had systems in place to ensure patients were protected in the event of an emergency on site and whilst interacting on the telephone.</p>	

We saw that the practice had protocols in place to guide staff in the event of encountering a patient with serious or deteriorating health condition. There had been clinical oversight in its development and included “red flag” symptoms for conditions such as a heart attack, stroke, and sepsis. Staff we spoke with were confident in using this tool and were clear that they could approach senior clinical staff at any time, should they be concerned. Furthermore, staff were empowered to call emergency service support should they feel it was necessary.

Information to deliver safe care and treatment.

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written, and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Our review of patient records following our remote searches of the providers’ clinical system identified that care records were managed in a way that protected patients. We saw that alerts or “pop-ups” were in place to draw the attention of staff to specific needs of patients. This was to ensure appropriate care was provided in a person-centred way. For example, some patients had alerts concerning their conditions, frailty levels, physical or sense impairments and/or learning disabilities or dementia.</p> <p>We found some issues with monitoring of patients test results, but the provider addressed this during the inspection period. Overall, we were confident that the practice was providing safe clinical care to their patients.</p>	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.96	0.98	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected	4.6%	7.8%	7.8%	Tending towards

antibacterial drugs (BNF 5.1 sub-set). (01/07/2022 to 30/06/2023) (NHSBSA)				variation (positive)
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)	4.14	5.04	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)	189.5‰	167.6‰	129.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	1.68	0.76	0.54	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	7.8‰	7.4‰	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
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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y

The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>We asked the practice about their prescribing of anti-biotic medicines and how they achieved a lower-than-average number of prescribed items. They told us that they took anti-bacterial stewardship very seriously and all clinicians worked to strict protocols to ensure this was maintained. This was discussed in clinical meetings and peers were held to account in a supportive way where necessary.</p> <p>Higher than average prescribing of pain medicines and the ‘hypnotic’ class of medicines were also explored with the provider, who explained that this was a historic issue that had been inherited previously. They demonstrated that audits were continually conducted alongside measures in patient education and slow reductions in prescribing to ensure that this improved over time. They acknowledged that this takes time and would continue to monitor this and make changes and continued improvements where necessary.</p> <p>The practice had emergency medicines and equipment in place appropriate to general practice.</p> <p>We saw that Naloxone (a medicine used to counteract an overdose of certain medicines that may be addictive or at risk of being abused) was not present, but the practice had considered the risk of this formally. Upon reviewing this document however, we found that this had not considered the risk encountering a patient that was not on their patient list that may have taken an overdose. The provider told us that they would be putting formal mitigating actions in place to ensure Naloxone was available from local pharmacies and other procedures including calling for emergency service support. Following the inspection, the practice informed us that this medicine had been put in place in line with national guidance.</p> <p>They also did not have powerful pain relief medicines in place in the event of an emergency and told us that this would also be mitigated in the same way.</p> <p>All other recommended emergency medicines were in place and there was a formal system to ensure that they were checked regularly (monthly) to log usage and expiry dates.</p> <p>Emergency equipment was owned and maintained by the building managers, but the practice had gained assurances that these were being completed appropriately. We saw that both oxygen cannisters and defibrillator (defib) machines were checked weekly by health centre staff and were in working order, including having defib pads for children and oxygen masks for children.</p> <p>The practice did not have controlled drugs on site.</p> <p>We found evidence that some patients had not been monitored appropriately in relation to patients taking medicines that help reduce blood pressure and some patients who had been overprescribed medicine to help them with their asthma. During the inspection the provider ensured that all patients we had identified, of which there were a limited number, had processes in place to mitigate the risk and ensure that their monitoring was up to date, or action had been taken to encourage them to engage.</p>	

We found that vaccine fridges and cold chain were managed appropriately with formal and comprehensive systems in place. We found that temperatures were checked regularly and there was guidance in place to support staff should temperatures exceed the parameters set out in national guidance.

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:	58
Number of events that required action:	58
Explanation of any answers and additional evidence: The practice had a comprehensive system around significant events that included identifying and raising them, mitigating the risk involved and learning from them. The practice had implemented a process to make it easier for staff to report incidents through placing a QR (quick response) code in each room used by the practice in the health centre. This code, once scanned by a smart phone, would take the user directly to an incident form that was easy to complete, which could then be sent directly to the manager for review. The practice told us that this is why so many had been reported in the last 12 months and this had helped them to analyse the trends and take action where necessary.	

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

Event	Specific action taken
Emergency incident	The practice demonstrated that their emergency procedures were working as intended following an incident involving a patient who was experiencing an emergency deterioration of health.
Fire warden lacking	Following an incident where it became clear that the practice was lacking fire wardens, the practice trained 5 fire wardens to ensure one was in place at all times.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y

Explanation of any answers and additional evidence:

We saw examples of actions taken on recent alerts, for example, SGLT-2 inhibitors (used in the treatment of diabetes but has associated risks of developing necrosis of some areas of the patients skin). The provider was able to demonstrate that all relevant safety alerts we reviewed had been responded to and action taken to protect patients and keep them informed.

Effective

Rating: Good

The practice was rated good for providing effective services because they were able to demonstrate that staffing was effectively managed, issues with prescribing, immunisations and screening had been identified and actions were being taken to address these. They also were able to demonstrate that antibacterial stewardship was a high priority.

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 were 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:	

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 experiencing poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- We found that out of the 5 patients with asthma who had been prescribed steroids, whose records we reviewed, 1 had not been followed up within the recommended time period. The practice addressed this immediately during the inspection and assured us that this would happen going forward.
- We also found that out of the 5 patients with Hypothyroidism whose record we reviewed, 2 had not had appropriate blood tests completed. Again, the practice addressed this immediately and ensured that all patients going forward would have this monitoring completed.
- Of the 5 patient records we reviewed who were diagnosed with diabetic retinopathy, we found 2 patients that did not have an annual review completed in line with national guidance. The practice addressed this immediately and ensured that all patients with this condition would get appropriate reviews going forward.
- We were confident that these patients constituted a small number in comparison to the number of patients registered with these conditions, representing low risk to the patient population as a whole. However, we advised the practice of our expectations and they had put systems in place to ensure that any gaps were addressed going forward. The practice also had access to our clinical searches, which they told us they would incorporate into their ongoing audit system.
- Patients with long-term conditions were generally 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, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

- Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e., three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	28	34	82.4%	Below 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)	42	46	91.3%	Met 90% minimum
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)	43	46	93.5%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps, and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	42	46	91.3%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps, and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	58	71	81.7%	Below 90% minimum

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

Any additional evidence or comments

The practice was aware of their lower than target uptake of childhood immunisations in relation to 2 out of the 5 indicators above.

They explained that this data was in relation to older data before the current partnership makeup had come into effect. Unverified data provided by the practice indicated that for children aged 1, 124 were eligible, 24 were due, 1 had refused to engage, 5 had declined immunisations and 19 were booked in for completion. This would bring the practice to 95.2% completion in this area.

The practice was unable to provide data for those children aged 5 (as above), we advised the practice to seek Childhood Immunisation Service (CHIS) data to compare to the data reported here and take appropriate action to address this.

Staff we spoke to about this told us that they had high levels of resistance from parents not wishing to allow their children to have vaccines due to misinformation circulated on social media. These patients had been booked in with a nurse, who explained how important these were and to dispel the false information, but many continued to refuse. Those who refused had their decision documented on the system and the practice had discussions with other health care professionals to continue to education of these patients.

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)	50.7%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	61.7%	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)	65.6%	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)	38.5%	54.3%	54.9%	No statistical variation

Any additional evidence or comments

The practice was aware of their lower than target uptake of cervical screening. This data was more recent, but the practice did not recognise this as their data was telling them they were fully compliant.

Unverified data provided by the practice indicated that for eligible persons aged 25 – 49, 85% had been screened and for eligible persons aged 50 – 64, 82% had been screened.

We advised the practice to seek Public Health England (PHE) data to compare with their data and take appropriate mitigating actions.

All areas of cancer screening (and detection) were lower than local and national averages and the practice had begun incorporating this into their audit cycles to ensure this was monitored and appropriate action could be taken to address any low areas.

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 that the practice had a comprehensive system of ongoing quarterly 'rolling' audits that covered a range of areas including long-term conditions and prescribing. For many these had only been completed in single cycles (two or more cycles would allow the practice to compare their results to ensure improvement had been achieved), but the practice explained that this system was newly established following changes to the provider partnership.</p> <p>We saw audits pertaining to anti-psychotic, lithium, amiodarone, and anti-bacterial prescribing. Of these, all except the lithium audit was single cycle. The lithium audit had been completed in June 2023 and again in September 2023 and demonstrated better engagement with 4 patients that had overdue monitoring.</p> <p>We found that the practice had completed a diabetes audit in May 2023 that demonstrated improvements and better outcomes for patients from the previous one in 2022.</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>All staff had a learning profile, and this was monitored by the management of the practice. We saw that all appropriate training had been completed in the staff files we reviewed.</p> <p>The practice demonstrated appropriate supervision was in place for staff who had complex patient facing roles, such as nurses and HCAs. These were formal and included audits of consultations and treatment decisions.</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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a register of patients who were in receipt of palliative care, plus those patients that were in their last year of life and those who would likely be moving to this list soon. These patients were colour coded depending on the level of support and input they required to maintain dignity and pain management. The practice was signed up to the Gold Standard Framework (GSF – a recognised way of forward planning for patients in these circumstances to ensure improved outcomes) and regularly consulted with other professionals to ensure joined up and coordinated care.</p> <p>The practice had access to a social prescriber that was employed by the PCN. Patients were referred to this professional, with consent, to facilitate access to community health and wellbeing services that aided with all aspects of a patient's life, including smoking cessation, weight loss, housing and mental health.</p>	

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance but there were some gaps.

	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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial
<p>Explanation of any answers and additional evidence.</p> <p>Upon reviewing 4 DNACPR records, we found that 3 documents did not sufficiently document capacity assessments relating to those patients ability to contribute to the process. We also found that there was no formal process in place to ensure reviews were completed when the patient's---- circumstances changed. We did, however, find that reviews had taken place following changes to patients circumstances as outlined in the practice policy, but this was inconsistent. For example, we found in 1 document that details had been copied from a previously completed form without additional consultation with the patient. The practice told us that this would be raised as a significant event and that learning would be applied to ensure that a formal process was established for clinicians to follow, along with oversight to ensure this was completed. These would be included in the rolling system of audits completed by the practice.</p>	

Caring

Rating: Good

The practice was rated good for providing caring services because patient satisfaction data was consistently high, although the practice continued to explore ways to improve and address the concerns of those patients that remained unsatisfied.

Kindness, respect, and compassion
Staff treated patients with kindness, respect, and compassion. Feedback from patients was generally 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

Patient feedback	
Source	Feedback
GP Patient Survey (GPPS)	Patient feedback in relation to the caring key question from the GPPS was in line or higher than local and national averages.
Family and Friends Test	Feedback generally on the family and friends test was positive in relation to the caring key question. We reviewed 7 months of results and found that in all cases there were high levels of satisfaction (approx. 90% and above), with the exception of September 2023, which dropped to 72%, but this was due to a technical issue the practice had addressed.
NHS Choices	Of the four comments left on the NHS Choices website in relation to the caring key question, 2 comments were positive, and 2 comments were negative.

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	93.6%	85.4%	85.0%	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 (01/01/2023 to 30/04/2023)	92.3%	84.4%	83.8%	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	98.1%	92.2%	93.0%	No statistical variation

healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	81.9%	71.2%	71.3%	No statistical variation
				Y/N
The practice carries out its own patient survey/patient feedback exercises.				Y

Any additional evidence

The practice was aware of their high levels of satisfaction but had continued to make improvements and consider the opinions of those patients who were not satisfied. We saw that they had also surveyed 437 patients in March 2023 to continue their engagement with their population. This included questions concerning how caring the service was, social prescribing, digital accessibility, and the appetite for patients joining the patient participation group (PPG). Responses demonstrated further work was needed, although satisfaction remained generally high.

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: We were told that easy read and pictorial materials were available where necessary and we saw that a hearing loop was in place and working. As a modern health centre, physical access was facilitated by ramps and automatic doors.		
Source	Feedback	
Interviews with patients.	Patients we spoke with expressed positive comments in relation to how they felt treated by the practice and their staff.	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	89.8%	89.1%	90.3%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice has 125 carers registered and was able to demonstrate that new patient forms are designed to capture this information. We saw that information was available to enable carers to access support and social prescribers were available to facilitate this process.
How the practice supported recently bereaved patients.	Bereaved patients were offered condolences as well as a wellbeing check and access to community support or counselling where necessary.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Good

The practice was rated good for providing responsive services because they were able to demonstrate that patient satisfaction was generally good and those areas that were not were actively addressed appropriately. Complaints were handled in a timely and appropriate way and used to aid learning.

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 practice demonstrated that they provided opportunities for patients to feedback to them in relation to services offered, including access to appointments. This feedback was generally positive, but the practice was aware of those comments that were negative and were proactive in addressing the concerns of patients and managing their expectations. We were told that appointments were prioritised for those patients that were vulnerable and needed additional support. For example, those patients with learning disabilities were offered appointments during less busy times.	

Practice Opening Times	
Day	Time
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
The practice was closed at weekends, but signposted patients to out of hours (OOH) services provided by NHS 111 and Go To Doc.	Additional appointments were available on weekends from 10am until 1pm through the primary care network (PCN).
Appointments available:	
Monday	8am – 6.15pm
Tuesday	8am – 6.15pm

Wednesday	8am – 6.15pm
Thursday	8am – 6.15pm
Friday	8am – 6.15pm

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

- Patients with vulnerabilities and who were elderly had a named GP who was responsible for their care supported them in whatever setting they lived. This did not mean that this doctor would see this patient each time but would provide oversight of the care provided.
- 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, this was delegated to the out of hours provider, who was made aware of circumstances where this might be necessary. This was to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Nursing appointments were available until 6.30pm on weekdays 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 had a triage system in place to ensure that clinical need was prioritised.
- The practice was open until 6.30pm on a Monday to Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP PCN. Appointments were available Saturday and Sunday 10am until 1pm.
- The practice held a register of patients living in vulnerable circumstances including homeless people, 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 generally able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment, or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g., face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence:	

The practice offered a range of appointments, and generally feedback from patients was positive about access to care and treatment. Not all patients were satisfied, and the practice explained that these individual concerns were considered and addressed where possible through the complaints process.

The practice acknowledged the common challenge of patient demand for appointments and assured us that they were taking all necessary steps to address this and provide we saw that they were providing a responsive service and meeting the needs of patients according to clinical need.

The practice was aware of their high levels of satisfaction but had continued to make improvements and consider the opinions of those patients who were not satisfied. We saw that they had also surveyed 437 patients in March 2023 to continue their engagement with their population. This included questions concerning access. Responses demonstrated further work was needed, although satisfaction remained generally high.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	52.0%	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)	65.1%	55.2%	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)	64.4%	56.2%	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)	84.7%	71.0%	72.0%	No statistical variation

Any additional evidence or comments

Feedback generally on the family and friends test was positive in relation to the responsive key question. We reviewed 7 months of results and found that in all cases there were high levels of satisfaction (approx. 90% and above), with the exception of September 2023, which dropped to 72%, but this was due to a technical issue the practice had addressed. GP patient survey data was higher than local and national averages, although there were no statistical differences in these scores.

Source	Feedback
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NHS.uk website (formerly NHS Choices)	Of the 8 comments left on the NHS website in relation to access, 3 comments were positive, and 5 comments were negative. The practice had responded to each comment offering support.
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Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care/
Complaints were not used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	12
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient confusion	As a result of 2 complaints in relation to patients confusing process in the practice, information posters were updated and posted around the practice to ensure all patients were aware of the processes in question.

Well-led

Rating: Good

The practice was rated good for providing well-led services because they were able to demonstrate that systems and processes to ensure good governance were in place and working as intended. Leaders were able to articulate their plans, processes and expectations, that were mirrored by conversations we had with staff.

Leadership capacity and capability

There was compassionate, inclusive, and effective leadership at all.

	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: Staff we spoke with told us that leaders were present and approachable, and they felt supported in their roles and engaged in out of work activities to boost well-being and teamworking.	

Vision and strategy

The practice had a clear vision and 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 we spoke with were happy working at the practice and were able to articulate their roles in achieving the priorities of the provider. They spoke passionately about their role in supporting patients and were clear that communication within the practice was at a high standard that worked for them.	

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>All relevant equality training had been completed by staff and the practice ensured effective oversight of this through monitoring of a matrix, along with system prompts.</p> <p>Our conversations with staff throughout the practice provided assurances that culture was overseen by leaders and our review of governance systems in place demonstrated sufficient processes to ensure concerns could be raised within or outside the practice should the need arise. Staff felt unconcerned about raising issues and felt these would be addressed.</p>	

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 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: Systems and processes in relation to risk management, were in place and working as intended. Our review demonstrated that these were effective and staff we spoke with understood how to engage with these to keep themselves and patients safe.	

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
Online consultations took place in appropriate environments to ensure confidentiality.	N/A
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

The practice did not provide online consultations.

The practice had the capability to work remotely should the need arise and had business continuity plans in place to provide structure to this.

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

Feedback from Patient Participation Group.

Feedback

Patients we spoke with explained how the PPG worked and were satisfied that this process gave them a voice to contribute to practice life and to ensure that patients perspectives were considered for any changes that happened in the practice. This also gave them the opportunity to suggest and drive changes and improvements where possible.

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:	

Examples of continuous learning and improvement

The practice had begun a rolling system of audits that allowed them to map any concerns and address them, including the issues initially identified by the remote CQC searches, which were then addressed. They demonstrated that patients and staff were listened to, to drive changes and improvements. The leaders we spoke with were open to input and feedback, as well as open conversations to ensure learning at all levels.

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.