

Inspection Evidence Table

Langstone Way Surgery

(1-540666441)

Inspection Date: 21 August 2023

Date of data download: 15/08/2023

Overall rating: Requires improvement

We carried out an announced comprehensive inspection at Langstone Way Surgery on 21 August 2023. This was a follow up to the inspection carried out in February 2022, when the practice was rated as Requires improvement. The practice was served a warning notice under Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a requirement notice under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we have again rated the practice as Requires improvement overall. We rated the practice as Requires improvement for Safe, Effective, Caring and Responsive; and Inadequate for Well-led.

- The health and safety risk assessment completed by the practice highlighted that a legionella risk assessment was due in January 2023. However, this had not been completed.
- Portable appliance testing had not been completed in the expected time period, by June 2023. However, we saw it had been booked for 30 August 2023.
- Equipment calibration had not been completed in the expected time period, by 9 August 2023. However, we saw it had been booked for 7 September 2023.
- There was no formalised process in place for managing GP workflow during times of absence.
- The practice did not always monitor patients who were prescribed medicines for long-term conditions.
- The practice had a policy and system in place to manage Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts; however, this was not fully effective.
- The practice mostly completed single-cycle audits. The limited two-cycle audits that we saw did not have a clear aim as to the purpose they served and whether any improvements happened as a result.
- Some staff we spoke with did not feel senior management were visible or fully effective in their approaches to leadership.
- Not all staff were able to name the safeguarding lead at the practice. Additionally, some staff did not know where to access the practice safeguarding policy.
- The practice identified that access to GP appointments was an ongoing issue. However, patient feedback found patients remained dissatisfied with the appointment booking system.

Please see below for detailed findings.

Safe

Rating: Requires improvement

- During our inspection in February 2022, we found that the practice was not always monitoring patients appropriately prior to issuing their next high risk medicine prescription. During this inspection, we found the practice had made improvements and that patients prescribed high risk medicines were monitored in line with national guidance.
- During this inspection, our review of patient records identified a total of 228 patients taking a medicine or group of medicines used to treat hypothyroidism. Of these we identified 16 patients who appeared to be overdue appropriate monitoring. We sampled 5 of these and found that there were problems with the care for 3 patients. With 2 out of the 3 patients, the practice had attempted to make contact; however, it was not fully clear if the practice was using different means to try and reach patients.
- During our inspection in February 2022, we found that the system for managing Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts was not always fully effective. During this inspection, we continued to find concerns regarding the management and communication of such alerts.
- Not all of the staff at the practice had safeguarding training applicable to their role.
- Some staff were unclear on how to access policies at the practice, and whether or not the practice had a whistleblowing policy.
- At the time of the inspection, the practice did not have up to date portable appliance testing, equipment calibration or legionella testing.
- There was no formalised process in place for managing GP workflow during times of absence. The lead GP described a buddy system and explained other GPs would check colleagues' inboxes when they were absent; however, there was not a robust system in place for managing this.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse; however, these were not always fully clear.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice held adult and children safeguarding risk registers and provided evidence of safeguarding being discussed at weekly clinical meetings. • The practice had a system in place to prioritise patients who may be vulnerable. For example, newborn children and those with no fixed abode were given priority access to appointments. • All clinical staff were assigned Level 3 children safeguarding and Level 3 adult safeguarding training. However, we reviewed 2 clinical staff member personnel files, and 1 member of staff had not completed their Level 3 adult safeguarding training. • The practice had a safeguarding policy in place; however, at the time of inspection, this had not been recently updated to reflect staff changes. This meant that those named as the safeguarding and deputy safeguarding leads on the policy document were not up to date. Immediately following inspection, the practice sent the updated safeguarding policy, with the safeguarding leads amended. • Not all of the staff were able to name the safeguarding lead at the practice. Additionally, some staff did not know where to access the practice safeguarding policy.
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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> <ul style="list-style-type: none"> • The practice carried out appropriate pre-employment checks and kept evidence of this in staff personnel files. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment:	September 2022
There was a fire procedure.	Y
Date of fire risk assessment:	5 January 2023
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • A fire risk assessment by an external contractor was completed on 11 November 2021. The practice then completed an in-house fire risk assessment on 05 January 2023. • We saw evidence that actions identified from the fire risk assessment on 11 November 2021 had been actioned and reviewed accordingly on 05 January 2023. • The health and safety risk assessment completed by the practice highlighted that a legionella risk assessment was due in January 2023. However, this had not been completed, despite this date being the given date for review following a legionella risk assessment completed by an external contractor on 14 January 2022. • Portable appliance testing was completed by an external contractor in June 2022 and equipment was due to be retested in June 2023. However, this had not been completed. An email was sent from the external contractor to the practice on 07 August 2023 to ascertain whether portable appliance testing 	

needed to be booked. There was no attempt from the practice to book the portable appliance testing prior to the old certificate expiry in June 2023. The practice subsequently provided evidence of the portable appliance testing being booked for 30 August 2023.

- Equipment calibration was completed by an external contractor on 09 August 2022. This was due to be repeated by 09 August 2023. However, this had not been completed. The practice reported the external contractor was running behind due to staff sickness and other commitments; however, no evidence of this was provided. The practice subsequently provided evidence of the equipment calibration being booked for 07 September 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:	05 January 2023
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • An infection prevention and control audit was completed by an external contractor on 05 January 2023. • The practice completed in-house hand hygiene audits, with the last one completed on 18 July 2023. 	

Risks to patients

There were gaps in 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.	Partial
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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a comprehensive induction pack for locum staff. • All staff received basic life support training, and reception staff were able to describe how to manage acutely unwell or deteriorating patients. 	

- Some of the staff we spoke with felt the practice needed more non-clinical and clinical staff to meet patient needs and provide more appointments.
- There was no formalised process in place for managing GP workflow during times of absence. The lead GP described a buddy system and explained other GPs would check colleagues' inboxes when they were absent; however, there was not a robust system in place for managing this.
- We found 68 blood results which required action. We reviewed the 3 earliest results, with the earliest result being dated 27 June 2023. 1 of these 3 results required action which had not been completed.
- We found 349 documents which had not been filed. We reviewed the 5 earliest results, with the earliest result being dated 08 August 2023. 1 of these 5 documents required action which had not been completed.
- The lead GP advised that due to staff shortages, administrative staff had been helping on reception, but that they had now returned to help assist with the backlog of documents.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment. However, systems in place were not always fully effective.

	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.	Partial
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> <ul style="list-style-type: none"> • Physician associates and advanced nurse practitioners employed by the practice had clinical oversight from the duty GP, who reviewed their prescribing and notes during designated time set aside. • There was not a robust system in place to ensure that test results were always managed in a timely manner, especially during periods of GP absence. 	

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) (01/04/2022 to 31/03/2023) (NHSBSA)	0.55	0.65	0.91	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) (NHSBSA)	8.1%	8.8%	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 (01/10/2022 to 31/03/2023) (NHSBSA)	5.86	5.54	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	55.2‰	61.5‰	129.9‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.81	0.54	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	6.7‰	6.0‰	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.	Partial

The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> The practice stocked appropriate emergency medicines. However, the practice did not stock 1 item that we would expect to find. Dexamethasone or prednisolone is used to treat croup in children, and the practice did not have this in their emergency medicines supply. The practice advised that an urgent prescription would be issued and obtained from the pharmacy next door if required; however, there was no formal risk assessment for this process shown to CQC on the day of the site visit to determine if it would be safe. Following inspection, we were sent evidence of a risk assessment from September 2022 detailing why the practice did not stock this medicine. The clinical searches identified a total of 228 patients taking a medicine or group of medicines used to treat hypothyroidism. Of these we identified 16 patients who appeared to be overdue appropriate monitoring. We sampled 5 of these and found that there were problems with the care for 3 patients. With 2 of the 3 patients, the practice had attempted to make contact; however, it was not fully clear if the practice was using a variety of means to try and reach patients. 	

Track record on safety and lessons learned and improvements made

The practice did not always make 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.	Partial
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	8
Number of events that required action:	8
<ul style="list-style-type: none"> Although the practice had a system in place to document when things went wrong, it was not always clear that once information regarding a significant event had been shared that changes were made to mitigate the risk of these events reoccurring. 1 clinical member of staff did not know where to locate the whistleblowing policy, therefore we were concerned that not all staff members could escalate issues via the appropriate channels. 	

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

Event	Specific action taken
Letter provided to patient to take to hospital appointment with another patient's details on it (both patients had the same name).	Letter of apology sent to patient, reported on Data Security and Protection toolkit, discussed in clinical meeting.
Letter from specialist doctor advised of issue with blood results, but not clear to GP that this required further monitoring. Patient then admitted to hospital.	Discussion between GP and specialist doctor regarding the importance of flagging such issues clearly on correspondence.

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> <ul style="list-style-type: none"> The practice discussed safety alerts at clinical meetings and this was a standard agenda item on the meeting minutes. The practice had a policy and system in place to manage Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts; however, this was not fully effective. For example, our clinical searches identified 26 patients prescribed teratogenic medicines who were of childbearing age. Teratogenic medicines have the potential to increase the risk of birth defects and developmental disorders when taken during pregnancy, especially during the first trimester. Of the 26 patients identified, 5 patient records were looked at. 2 of these 5 patients did not have documentation in their clinical records to evidence that the risk was discussed with the patient or alternative treatments considered. 	

Effective

Rating: Requires improvement

- During our last inspection in February 2022, we found that the practice was not always reviewing patients' blood results before issuing their next high risk medicine prescription. There was not an effective system in place to ensure that any blood results obtained from a third party were reviewed and used to guide safe prescribing of high-risk medicines. During this inspection, we found that patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance.
- The practice was not reviewing its performance against its quality improvement plan at regular intervals.
- The practice mostly completed single-cycle audits. The limited two-cycle audits that we saw did not have a clear aim as to the purpose they served and whether any improvements happened as a result.
- Completed induction checklists were not always available in staff personnel files.
- Patients with a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decision did not always have a copy of this attached to their electronic clinical record.
- The practice did not always engage effectively with hard-to-reach patient groups. For example, 14 out of 30 patients who were identified as having a learning disability had not been seen for their annual review within the preceding 12 months.

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; however, care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance..

	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.	Partial
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
<ul style="list-style-type: none"> • The practice implemented a system to highlight the most vulnerable patients and stratified these patients into either Gold, Silver or Bronze access. This helped to ensure that those patients who had additional needs identified were supported in the best way possible and given priority access to appointments. In addition, these patients were coded, so that reception staff could be informed and act appropriately if such patients were trying to obtain an appointment. • We found some gaps in the monitoring of patients prescribed medicines for long-term conditions. 	

Effective care for the practice population

Findings
<ul style="list-style-type: none"> • The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. • Health checks, including frailty assessments, were offered to patients over 75 years of age. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. • 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. However, 14 out of 30 patients who were identified as having a learning disability had not been seen for their annual review within the preceding 12 months. The practice reported that many patients did not attend for their booked appointments; however, we had concerns that the practice was not always proactively trying to capture this patient group using a variety of means. • 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

- 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.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients who required high dose steroid treatment for severe asthma episodes were followed up in line with national guidance to ensure they received appropriate care.
- Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance. The clinical searches identified a total of 228 patients taking a medicine or group of medicines used to treat hypothyroidism. Of these we identified 16 patients who appeared to be overdue appropriate monitoring. We sampled 5 of these and found that there were problems with the care for 3 patients. With 2 of the 3 patients, the practice had attempted to make contact; however, it was not fully clear if the practice was using different means to try and reach patients.

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 influenzae 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)	107	120	89.2%	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)	101	111	91.0%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	98	111	88.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and	101	111	91.0%	Met 90% minimum

rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
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)	119	149	79.9%	Below 80% uptake

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

Any additional evidence or comments
<p>The practice was aware of their current figures and had detailed how they had tried to improve uptake of childhood immunisations. For example, clinicians would opportunistically invite eligible children to receive their immunisations if their parent or guardian (or the child themselves) was attending for an unrelated appointment.</p> <p>Although the practice had improved their uptake of childhood immunisations and it being on an upwards trajectory since 2019 for all indicators listed above, the practice remained below the WHO target of 95%.</p>

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)	55.5%	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)	62.6%	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)	65.9%	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)	52.2%	55.6%	54.9%	No statistical variation

Any additional evidence or comments
<p>The practice was aware of their current figures and told us they were opportunistically inviting eligible females to book in for a cervical smear when such patients attended for unrelated reasons.</p>

Monitoring care and treatment

The practice had a programme of quality improvement activity. However, it was unclear as to how often this was reviewed and how it was used to drive improvement.

	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.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: <ul style="list-style-type: none">The practice had devised a quality improvement plan and had updated this periodically. However, it was not clear whether this was being reviewed at set intervals to monitor progress. There were 2 updates documented on the quality improvement plan from December 2021 and January 2023.The practice mostly completed single-cycle audits. The limited two-cycle audits that we saw did not have a clear aim as to the purpose they served and whether any improvements happened as a result. For example, there was a two-cycle review on strong opiate prescribing, which appeared to simply show search results of what medicines patients were prescribed on a particular date, rather than any intervention between the cycles to bring about any changes.	

Any additional evidence or comments

Strong opiate prescribing – 2 audit cycles completed to ascertain how many patients were prescribed moderate to high strength opiates and issued in quantity for monthly supplies.

Semaglutide prescribing – 2 audit cycles completed to ascertain how many patients were prescribed semaglutide 1mg injections and how to manage such patients during temporary stock shortage.

Effective staffing

The practice was not always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. We did not see evidence of an induction programme for non-clinical staff.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
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.	Partial
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> <ul style="list-style-type: none"> • Both clinical and non-clinical staff were assigned training modules via an online platform. The training assigned to both clinical and non-clinical staff was appropriate for their job roles. • Non-medical prescribers had their prescribing reviewed at regular intervals by both GPs and the primary care network (PCN) pharmacist. • We found evidence of an induction programme for clinical staff; however, we reviewed 2 non-clinical staff personnel files and saw no evidence of an induction programme. The practice advised that the member of staff responsible for non-clinical staff member inductions was absent and that the practice did not have access to where these are stored. • We did not see evidence of staff appraisals or review meetings, and the 2 non-clinical staff personnel files we checked did not have completed induction checklists included. Immediately after the inspection, we were sent copies of 2 of the review meetings (1 for a clinical staff member and 1 for a non-clinical staff member). • Both clinical and non-clinical staff had reviews 3 months after they had commenced employment. Whilst we saw evidence of this, reviews completed were unstructured and lacked detail. Therefore, we were concerned that performance was not always managed consistently. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice worked closely with PCN staff and social prescribers to deliver personalised and holistic care. • The practice showed awareness of issues with transitions in services (particularly mental health) and detailed how the social prescribers have been working closely with the practice to support those in vulnerable situations. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Nursing staff interviewed were able to describe how they refer patients on to other services (for example: Health visitor, social services, respiratory specialist nurse, social prescriber, exercise services). 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We reviewed the clinical notes of 6 patients where a DNACPR decision had been recorded. 3 out of the 6 patients resided in a nursing home. Whilst the clinical notes detailed that a DNACPR decision had been made, these 3 patients did not have a copy of their DNACPR decision in their electronic patient record. We found no issues with the other 3 of the 6 patients we reviewed who had a DNACPR decision in place. Decisions regarding the mental capacity of a patient were clearly documented in their clinical records. 	

Caring

Rating: Requires improvement

- The practice detailed the actions it was taking in response to patient feedback. However, patient feedback received by the practice remained largely negative in nature. Patients did not always feel they were treated with kindness, respect and compassion.
- The practice had not undertaken any specific feedback to evaluate the success of the changes implemented. Therefore, the effectiveness of the actions was not fully clear.
- Results from the GP Patient Survey indicated that patients did not always feel that the healthcare professional they saw was good at listening to them. The results of the GP Patient Survey in relation to the practice providing caring services had remained below local and national averages since 2022.

Kindness, respect and compassion

Feedback from patients was largely negative about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff interviewed were able to describe ways in which they ensured the personal, cultural, social and religious needs of patients were met. • Patients were signposted and referred onwards by clinical staff for further support as indicated. • On the day of inspection, we spoke with 1 patient at the practice. The feedback was largely positive in nature and they reported that staff treated them with kindness and dignity. However, feedback obtained from other sources was not always positive. For example, the GP Patient Survey results were lower than both local and national averages. • Positive reviews on NHS Choices mentioned competent nurses and GPs; however, other common themes that emerged from NHS Choices reviews referred to unhelpful reception staff and long wait times to contact the practice. 	

Patient feedback	
Source	Feedback
NHS Choices	<p>17 reviews dating back to January 2022. The ratings for the reviews are as follows:</p> <p>5 star – 1 review 4 star – 0 reviews 3 star – 0 reviews 2 star – 1 review 1 star – 14 reviews Non-rated – 1 review</p>

	<p>Negative feedback – Medication delays, unhelpful reception staff, difficulties getting through on the phone or being disconnected, long wait times to contact surgery (up to 40 minutes), poor management, appointments often running late</p> <p>Positive feedback – Competent nurses and GPs, knowledgeable and helpful receptionists</p>
GP Patient Survey	Please see table below.

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)	73.2%	83.5%	85.0%	Tending towards variation (negative)
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)	75.6%	81.4%	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 healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	89.6%	91.9%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	42.3%	68.7%	71.3%	Variation (negative)

Any additional evidence or comments

The practice had devised an action plan in response to feedback obtained from the GP Patient Survey results. However, there was little mention in the practice's action plan of what they were doing to improve the above indicators. Most items listed in the action plan related to access issues as opposed to patient experience with the healthcare professionals.

In addition, the practice had also created a development log, which used feedback from a variety of sources, (including staff members, Patient Participation Group (PPG) members and the Primary Care Network (PCN)) to drive improvements. One example of this was updating the protocols on the clinical records system to reflect if a patient had already had appropriate monitoring completed prior to their original due date.

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

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Explanation of any answers and additional evidence:

- Staff were able to describe how they adapted their approach to patient needs and how they accessed support from additional services (such as external interpreters) to help facilitate this.
- There was information available in the patient waiting areas regarding different clinics, such as travel and flu clinics.
- Posters detailing the chaperone service were seen in the patient waiting areas.

Source	Feedback
Interviews with patients.	Happy to be a patient at the practice, trusts clinical staff. Would like appointments to be more accessible as those with internet access seem to be able to obtain appointments with least difficulty.

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)	89.2%	88.4%	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Interpretation services (Language Line) could be used when English was not a patient's first language. • Information about clinics and services was available on the practice website, along with recommended apps which smartphone users could download and access. 	

Carers	Narrative
Percentage and number of carers identified.	179 (2.01% of 8890 patients)
How the practice supported carers (including young carers).	Carers were encouraged to be involved in decision making for patients who were deemed to lack mental capacity. The practice stated that people were encouraged to identify themselves as carers and proactively seek out support as needed. On the practice website homepage, there is a link to "Carer Information". This directs the user to a page where further information can be sought on carer support and carer's allowance, as well as giving a form for patients to fill in and alert the practice to their carer status.
How the practice supported recently bereaved patients.	Staff told us that if families had suffered bereavement, their usual GP or the senior nurse contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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: Requires improvement

We recognise the pressure that practices are currently working under and the efforts staff are making to maintain levels of access for their patients. At the same time, our strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. Although we saw the practice was attempting to improve access, this was not yet reflected in the GP patient survey data or other sources of patient feedback. Therefore, the rating is Requires improvement, as ratings depend on evidence of impact and must reflect the lived experience that people were reporting at the time of inspection.

- During our inspection in February 2022, we found that data from the National GP Patient Survey showed the practice was performing below local and national averages in relation to being able to contact the practice by telephone and satisfaction with appointment times. Reviews left by patients on the NHS Choices website suggested some dissatisfaction with responsive aspects of the service. We found similar concerns during this inspection.
- Whilst the practice detailed the improvements they had trialled in response to patient feedback, we found that many patients remained dissatisfied with their experience at the practice, particularly with accessing appointments.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. However, patients were not always satisfied with their experience at the practice.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
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.	Partial
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: <ul style="list-style-type: none">• The practice had a lowered desk and had access to 2 wheelchairs for use by patients with reduced mobility.• A hearing loop was installed at the reception desk.• Clear alerts were on patient records if English was not their first language.• Despite the practice's efforts, patient satisfaction remains low and scores were below local and national averages on the GP Patient Survey.	

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

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> • The practice used a Gold, Silver and Bronze access scheme in order to ensure the most vulnerable patients were identified and given the correct level of support to meet their needs. • 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. • Additional nurse appointments were available until 7:30pm on a Tuesday to accommodate for those patients with other daytime commitments. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. • People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

Access to the service

People were not always able to access care and treatment in a timely way. However, the practice reported making efforts to improve this.

	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.	Partial
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.	Partial
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> <ul style="list-style-type: none"> The practice implemented a system to highlight the most vulnerable patients and stratified these patients into either Gold, Silver or Bronze access. This helped to ensure that those patients who had additional needs identified were supported in the best way possible and given priority access to appointments. The practice identified that access to GP appointments was an ongoing issue, and detailed steps on how they had been trying to address this. For example, the practice staggered the release of appointments to ensure appointments were available to those booking online appointments, those calling the practice at 8:00am to make appointments (to not digitally exclude patients), and those making appointments later in the day if they had fallen ill suddenly in the morning. However, patient feedback from the GP Patient Survey, NHS Choices and feedback made directly to CQC advised that patients remained dissatisfied with the appointment booking system, with many patients stating that they were not able to get an appointment at all when they needed it. 	

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)	17.6%	N/A	49.6%	Significant variation (negative)
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)	26.6%	53.2%	54.4%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with	31.8%	53.6%	52.8%	Tending towards

their GP practice appointment times (01/01/2023 to 30/04/2023)				variation (negative)
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)	60.5%	68.2%	72.0%	No statistical variation

Any additional evidence or comments

- 3 of the 4 indicators above (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; the percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment; and the percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times) had been below local and national averages since 2018, and have been on a downward trend since 2021.
- 1 of the 4 indicators (the percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered) remains below local and national averages since 2021, despite a 14% increase during 2022-2023.
- The practice was aware that patient access was an ongoing issue; however, has demonstrated little proactivity in preceding years to improve patient satisfaction, and indicators in the National GP Patient Survey have been consistently below local and national averages for the past 5 years.
- The practice had recently implemented a new telephone system which enabled a call-back feature so that patients were not left on hold for long periods of time. Additionally, the practice found that releasing all of the appointment slots in one go often meant that those with computer access who booked online managed to reserve all of the slots before patients contacting the practice via phone could obtain any. This meant that those patients who were not computer-literate were disadvantaged. Therefore, the practice withheld a certain number of appointments for patients calling the practice. The practice found that some patients were getting ill during the morning and some patients required to be seen the same day, even though they were not able to call when the practice opened. For this reason, the practice also withheld appointments to be released at 1pm to accommodate this. No feedback was available at the time of the inspection to evaluate the success of these changes which had been implemented.
- 2 administrators had been employed to assist with booking patient appointments.
- The practice stated that face to face appointments were only available if a clinician deemed this as clinically necessary. Patients reported dissatisfaction with this when they provided feedback.

Source	Feedback
NHS.uk website (formerly NHS Choices)	<p>17 reviews dating back to January 2022. The ratings for the reviews are as follows:</p> <p>5 star – 1 review 4 star – 0 reviews 3 star – 0 reviews 2 star – 1 review 1 star – 14 reviews Non-rated – 1 review</p> <p>Negative feedback – Medication delays, unhelpful reception staff, difficulties getting through on the phone or being disconnected, long wait times to contact surgery (up to 40 minutes), poor management, appointments often running late</p>

	Positive feedback – Competent nurses and GPs, knowledgeable and helpful receptionists
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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. However, patients remained largely dissatisfied with the care they received

Complaints	
Number of complaints received in the last year.	92
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complained they were de-registered without their knowledge.	Explanation of de-registration reason sent.
Patient complained that GP had not called them to discuss test results.	Request made to GP to call back patient and discuss test results.

Well-led

Rating: Inadequate

- During our inspection in February 2022, we found issues with the receiving and actioning of MHRA alerts. We continued to find issues with actioning MHRA alerts during this inspection.
- Additionally, during inspection in February 2022, we found there were not always effective arrangements for identifying, managing and mitigating risks. This continued to be a concern during this inspection.
- During inspection in February 2022, we found that the practice was unable to provide evidence that learning needs were routinely identified and actioned as a result. During this inspection, the practice reported that they have been proactively using feedback from patients in attempt to improve patient satisfaction. However, this has not always been reflected in patient feedback.
- Additionally, there was limited evidence to demonstrate the effectiveness of actions taken to improve patient experience, despite poor patient satisfaction being an ongoing issue since the previous inspection in 2022.
- During this inspection, some staff we spoke with did not feel senior management were visible or fully effective in their approaches to leadership.
- We found during this inspection that the practice did not routinely review policies when staff members had ceased employment or had changed roles within the practice. For example, the safeguarding policy was not updated following recent staff departure. Additionally, some staff were unsure of who the safeguarding lead was. Immediately after the inspection, the practice provided evidence that this had been rectified and updated accordingly.
- During our clinical records review on this inspection, the GP specialist advisor found a backlog of documentation on the clinical correspondence system. Additionally, we saw no evidence of a robust system in place which the workflow of absent GPs was covered. Arrangements for cover during times of GP absence were informal and completed on an ad-hoc basis.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels, but it was not always fully effective.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Senior management identified challenges they faced and were proactive in their attempts to rectify such issues. However, this was not always reflected in patient or staff feedback, so we had concerns that these challenges were not fully understood. • The practice was able to state what measures had been taken so far to improve quality. For example, employment of staff to assist with backlogs of documentation and making improvements to their telephone system. • Some staff we spoke with did not feel senior management were visible or fully effective in their approaches to leadership. 	

Vision and strategy

The practice did not have 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.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice did not provide evidence of collaborating with patients and external partners to develop the vision, values and strategy.	

Culture

The practice could not evidence how it drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	N
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Not all staff we spoke with felt able to raise concerns with senior management.There was not always a strong emphasis on the safety and well-being of staff. Some staff we spoke with during the inspection detailed increased workloads and not enough measures in place to assist them with completing their roles.The practice did not always comply with the requirements of the duty of candour. For example, when things had gone wrong, it was not always documented in the significant events or complaints logs that affected parties had received a timely apology.	

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

Source	Feedback
Staff interviews	Many staff we spoke with felt that line management arrangements within the practice worked well. However, some staff felt that senior management were not always visible and were not always open to receiving constructive feedback.

Governance arrangements

There were responsibilities, roles and systems of accountability to support good governance and management. However, these were not always clear.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice did not routinely review policies when staff members had ceased employment or had changed roles within the practice. For example, the safeguarding policy was not updated following recent staff departure. Additionally, some staff were unsure of who the safeguarding lead was. Immediately after the inspection, the practice provided evidence that this had been rectified and updated accordingly. During our clinical records review, the GP specialist advisor found a backlog of documentation on the clinical correspondence system. Additionally, we saw no evidence of a robust system in place which the workflow of absent GPs was covered. Arrangements for cover during times of GP absence were informal and completed on an ad-hoc basis. The practice had not devised an action plan to clear the backlog of documentation with clear timeframes and quantifiable targets. 	

Managing risks, issues and performance

The practice did not always have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Both clinical and non-clinical staff had reviews 3 months after they had commenced employment. Whilst we saw evidence of this, reviews completed were unstructured and lacked detail. Therefore, we were concerned that performance was always managed consistently.• The practice did not have in-date certification for portable appliance testing, equipment calibration or legionella testing.	

Appropriate and accurate information

There was not always 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.	N
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• During the inspection, evidence was seen of staff members being held to account for specific significant events or complaints made.• However, it was not always clear what changes had been implemented and embedded as a result of adverse incidents occurring.	

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.	N/A

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. However, this was not always fully effective.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice identified and attempted to make improvements in response to patient feedback. However, a large proportion of patient feedback remained negative in nature, with many complaints raised regarding accessing appointments with the practice. The practice had a Patient Participation Group (PPG); however, the practice reported that membership was low. The practice advised they had actively tried to encourage membership by sending out invitations and varying the times of meetings, but to little avail. Not all staff we spoke with during the inspection felt senior management listened to, and acted on, their concerns. 	

Feedback from Patient Participation Group.

Feedback

Attendance has somewhat improved at the PPG, as the GPs and practice manager had been introducing the idea to patients. The PPG felt that more could have been done to encourage attendance at PPG meetings; however, ideas and suggestions raised as a result of PPG meetings were being listened to. For example, the PPG reported that the introduction of physician associates had been raised a while back, and has since been implemented.

Continuous improvement and innovation

There were not effective systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice reported that they have been proactively using feedback from patients in attempt to improve patient satisfaction. However, this has not always been reflected in patient feedback.• We saw evidence of significant events and complaints being discussed at practice meetings, with learning points being shared amongst the team. However, it was not always clear how learning points had resulted in changes being implemented and embedded within the practice.	

Examples of continuous learning and improvement

The practice had devised a practice development log, which detailed what had prompted the discussion, details of the discussion had, and the improvement(s) made as a result. For example, the practice had shortened their recorded telephone message by 16 seconds in response to PPG feedback reporting that the current message was too long in duration.

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 women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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