

# Care Quality Commission

## Inspection Evidence Table

### Minehead Medical Centre (1-545567250)

Inspection date: **2 November 2022**

Date of data download: 21 October 2022

## Overall rating: Requires Improvement

### Safe

### Rating: Requires improvement

We rated the practice as requires improvement for safe services because:

- Safeguarding processes were not established or operated effectively.
- Not all staff were up to date with safeguarding training or had received training appropriate to their role.
- Recruitment processes were not effective to ensure information was up to date at the point of employment.
- Risk assessments did not always contain necessary information.
- The practice had not monitored the performance of non-medical prescribers.
- Medicine reviews did not always contain necessary information.
- Safety alerts were not always actioned appropriately.

#### Safety systems and processes

**The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Staff were trained to appropriate levels for their role.	No
There was active and appropriate engagement in local safeguarding processes.	No
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial

Explanation of any answers and additional evidence:

Safeguarding processes were not embedded in practice. For example:

- The practice did not have a practice specific child safeguarding policy. They evidenced a general policy created by the Integrated Care Board (ICB) however, this did not contain guidance for practice staff on internal safeguarding processes.
- The practice told us they conducted monthly audits of children on child protection registers. However, they could not demonstrate that all children identified as at risk or of concern had been reviewed to ensure their safety. Our remote searches identified that not all codes applied to children records had been included in practice audits.
- The practice told us their monthly safeguarding audits were reviewed and discussed informally with the safeguarding lead. However, these reviews had not been documented and there was no record to demonstrate the searches had been conducted since June 2022.
- Staff told us if children were not brought to immunisation appointments, the practice would phone or text the patient's parent or guardian. However, this process had not been formalised and staff told us that due to staffing issues it was not done consistently. The practice was unable to advise if they had a process to review children not brought to other practice appointments. Staff we spoke with, including the practice's safeguarding lead, told us they were unclear if there was a process to review these patients. If immunisation appointments were missed for children on child protection registers, the practice told us they would be followed up by the health visiting team.
- The practice's safeguarding lead was not always aware of the practice's internal safeguarding processes. For example, they advised an administrator responded to information requests made by social services but was unsure what the process was should this person not be in practice. They advised that these requests would probably go to the practice manager but could not give assurance of the process.
- The practice were unable to demonstrate that information discussed with other organisations about children and adults at risk was disseminated internally to ensure necessary staff were aware of patient safety concerns.
- Feedback from local stakeholders included that the practice safeguarding lead attended training in March 2022 but had since not engaged with local safeguarding assurance processes. They advised that a safeguarding referral had been delayed as the practice had not used the correct referral pathways and that practice engagement with safeguarding processes were not always appropriate. This was highlighted to the practice who advised they would use this as a learning opportunity. A significant event was raised however, it was unclear what improvements had been implemented in response to concerns raised by local stakeholders.

Following inspection, the practice implemented a safeguarding standard operating procedure which detailed ongoing monitoring procedures for vulnerable patients. However, it did not contain all necessary information. For example, it did not specify actions required of the safeguarding lead following monthly audits conducted.

Not all staff were up to date with safeguarding training and the practice could not evidence that staff had received training appropriate to their role. For example:

- Levels of safeguarding training had not been specified in practice policy. The practice told us that they believed some clinical staff had completed safeguarding children level 2 training which was not in line with national guidance, however this could not be confirmed as they did not have oversight of this. Feedback from some clinical staff demonstrated that they were not aware of which level of safeguarding training they had completed.
- Staff training records identified 13 staff who were not up to date with safeguarding children training and 9 staff who were not up to date with safeguarding adults training.

Safeguarding	Y/N/Partial
The practice conducted DBS checks for all staff who completed their induction. This meant that there would be a period of approximately 3 to 4 weeks where a member of staff would be working for the practice without a DBS check. This had not been formally risk assessed, however the practice told us that during their induction, staff would not work alone.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
<p>Explanation of any answers and additional evidence:</p> <p>Recruitment files did not always contain necessary information. For example, we reviewed six staff files and identified:</p> <ul style="list-style-type: none"> <li>• Three files did not contain references from previous employers.</li> <li>• Two files did not demonstrate registration with regulatory bodies at the time of employment.</li> <li>• Two files did not contain disclosure and barring service checks or an appropriate risk assessment.</li> </ul> <p>We discussed the gaps in information with the practice who advised that 2 members of staff had initially started work for the practice through external agencies. Recruitment checks would have been conducted at the time by those agencies. When the practice began direct employment of those staff, they had not completed their own recruitment checks or risk assessed the impact.</p> <p>Staff immunisation status was not up to date in line with practice policy and national guidance. For example:</p> <ul style="list-style-type: none"> <li>• Non-clinical staff were sent a letter at the point of employment, advising which immunisations were recommended and if required they could book some time with a practice nurse to discuss further. However, the practice did not keep a record of which immunisations this staff group held and the impact had not been risk assessed.</li> <li>• The practice did not have a record of the immunisation status of clinical staff recruited in the last two years. This oversight had not been risk assessed.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various dates	Partial
There was a fire procedure.	Y
Date of fire risk assessment: 9 August 2021 Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>One action remained outstanding from the practice's fire risk assessment. An external company had conducted the assessment in 2021 and identified that fire doors installed in the older part of the practice building did not meet current fire standards. The practice told us that the fire doors in place at the time of inspection had met the fire standards at the point of installation but were aware that additional works were required to bring them up to current standards. They had discussed the risk with the company who had conducted the risk assessment and had received quotes for the remedial work required.</p>	

Other risk assessments conducted did not always identify potential risk or give opportunity to record actions. We saw that an additional fire risk assessment and health and safety risk assessments had been conducted in 2022. However, potential risk and actions taken were not recorded. For example:

- The fire risk assessment completed in March 2022 had not identified that the practice had not conducted a fire drill in the last 6 months or that the fire alarm testing was not actioned consistently. We saw that the fire alarm had not been tested for 1 week in August 2022 and 2 weeks in October 2022.
- It had not been documented on the fire risk assessment that there was not an evacuation chair if someone lost consciousness on the first or second floor of the building. We discussed this with the practice who told us this had been discussed with the fire officer and deemed unnecessary due to other mitigating factors. However, this had not been identified and recorded.
- The practice's health and safety risk assessments did not identify that legionella testing was not consistent. Monthly legionella tests were conducted to ensure water temperatures were in an acceptable range. However, when the responsible member of staff was away from work, the testing was not carried out.

Following inspection, the practice sent us an action plan demonstrating improvements they had implemented. This included a template to record potential risk and actions taken and additional staff were going to be trained to conduct fire alarm and legionella testing.

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: March 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: Not all staff were up to date with infection prevention and control training. We identified 12 members of staff, including clinical staff, that were not up to date with this training.	

## Risks to patients

### Systems to assess, monitor and manage risks to patient safety were not always embedded.

	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.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes

There were enough staff to provide appointments and prevent staff from working excessive hours	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice used locum GPs to help cover clinical sessions. They had also moved to an on-the-day appointment system for GP appointments where patients were fully triaged. Nurse and healthcare assistant appointments could be booked in advance. However, feedback from staff included that clinics were always full and there was approximately a 4 week wait for a long term condition review.</p> <p>The practice told us that, other than trying to recruit additional GPs, there were no other job vacancies across the practice. However, feedback received from different staff groups included that the practice had been trying to recruit additional clinical staff and that unforeseen absences could put pressure on remaining staff to meet patient demand. Those with additional responsibilities told us they found it difficult to find dedicated time to effectively carry out those roles due to the pressure to meet patient demand.</p>	

### 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.	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Patient records did not always contain information in line with guidance. Clinical searches conducted prior to inspection identified medicine reviews had been coded on patient records however, additional information was not always recorded to demonstrate if the medicines prescribed remained appropriate.</p>	

### Appropriate and safe use of medicines

#### The practice did not always have 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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.87	0.78	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	4.1%	4.6%	8.5%	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 (01/01/2022 to 30/06/2022) (NHSBSA)	3.60	3.86	5.31	Significant Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	132.3‰	116.4‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.70	0.53	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	8.4‰	6.2‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	No
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	No
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. <sup>1</sup>	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.	Yes

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. <sup>2</sup>	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Partial
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>Blank prescriptions were not monitored effectively in practice. The log book used to record and monitor the use of prescription stationary across the practice was not kept up to date and serial numbers for prescriptions did not always corroborate with the information recorded. We identified 3 boxes of blank prescriptions were open and in use and the practice was unable to demonstrate where those prescriptions had been assigned. Following inspection the practice conducted an audit of prescriptions held across the practice and implemented a new protocol. However, the protocol did not contain all information to give necessary guidance to staff. For example, it specified that it was the responsibility of each prescriber to ensure the security of prescriptions held in the clinical room used, however no guidance was given on what the practice identified as appropriate security measures.</p> <p>Patient group directions (PGDs) were not always signed and authorised in line with guidance. We identified that PGDs had been signed by necessary staff but they were not authorised in an appropriate time frame. For example, a PGD for the Rotavirus vaccine was signed by necessary staff in 2021 but it had not been authorised until September 2022. This meant that staff would have been administering a medicine to patients when they did not have the authority to do so or evidence to demonstrate they had been assessed as competent to assess patients appropriately.</p> <p>The practice could not be assured of the competencies of non-medical prescribers as this had not been monitored. The practice employed primary care practitioners (PCPs) and two had completed a prescribing qualification. However, they did not have access to formal regular clinical supervisions and the practice had not monitored their prescribing practice to ensure they acted within their own competencies and that prescribing decisions had been appropriate. Following inspection, the practice sent us evidence they had introduced a protocol to conduct an annual prescribing audit for non-medical prescribers. However, the</p>	

Medicines management	Y/N/Partial
practice was unable to provide assurances that an annual review would be effective in promptly identifying concerns so that necessary support could be implemented if required.	
<p>Medicine reviews did not always contain necessary information. We reviewed patient records and identified that when medicine reviews were coded, additional information including rationale for continued prescribing, was not always recorded. For example, we reviewed 3 records of patients diagnosed with hypothyroidism who had not received necessary monitoring in the last 18 months. We identified:</p> <ul style="list-style-type: none"> <li>• Medicine reviews had been coded on 2 patient records however, additional information was not available to demonstrate what had been included in the review. Additionally, no action had been taken to bring the patient in for necessary monitoring which was overdue at the point of review.</li> <li>• One patient had not received a medicine review or necessary monitoring since 2020 despite continued prescribing. However, when we inspected an appointment had been scheduled for November 2022.</li> </ul> <p>Following inspection, the practice advised that annual reviews for Hypothyroidism had been paused during the COVID-19 pandemic. They had not restarted recalling patients for reviews of their care and treatment until June 2022 and were working through the backlog.</p> <p>The practice did not have all recommended emergency medicines or equipment in place and had not risk assessed the impact. We identified the practice did not have pediatric defibrillator pads. Staff told us that if there was an emergency, they would perform CPR and could adjust the adult defibrillator pads as required. Staff told us that they had reduced emergency medicines held on site for example, we identified they did not have medicines in place to treat suspected heart attacks or strokes, or a muscle relaxant for potential seizures.</p>	

### Track record on safety and lessons learned and improvements made

#### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	11
Number of events that required action:	11

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence:	



Systems to ensure safety alerts were actioned appropriately were not embedded. We reviewed patients over the age of 65 prescribed 40mg Citalopram or 20mg Escitalopram which placed them at increased risk of arrhythmia. We reviewed 5 out of 9 patients affected and found automated alerts had been put on their clinical records but no additional action had been taken to discuss the risks with patients and change their prescribed medicines. We saw that medicine reviews had been conducted for 4 of the 5 patients in the last 12 months. However, 2 medicine reviews did not contain additional information or a rationale for continued prescribing. Two other medicine reviews did contain additional information, however they did not reference the prescribing of these medicines, the associated risk or if action was being taken to ensure patient safety. One of the 5 patients we identified had not received a medicine review since 2020. We discussed this with practice who told us that they had run a search of patients prescribed these medicines in 2021 and that a list of patients been given to clinicians. However, the practice was unable to demonstrate what further action had been taken. When we conducted our site visit, the practice told us that all patients in this cohort had been invited in for a review and that they would chase patients who did not attend. Following inspection, the practice sent us an action plan which stated they would conduct searches on MHRA alerts every 3 months, that actions taken would be recorded in patient notes and it would be added as a standard agenda item to the practice's multidisciplinary team meetings.

## Effective

## Rating: Requires Improvement

We rated the practice as requires improvement for providing effective services because:

- Processes to ensure staff had received or were up to date with training, were not embedded.
- Not all staff had received an appraisal.
- Staff did not always have access to appropriate support or clinical supervision.
- Uptake for child immunisations and cervical screening were below national targets and the practice had not identified actions to improve.
- Systems to ensure all patients requiring a review were identified, were not embedded.

*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 not always assessed, and care and treatment was not always 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Partial
Explanation of any answers and additional evidence: The practice told us annual reviews had not been done during the Covid-19 pandemic and were now prioritising patient recalls for those longest overdue. We saw that for patients prescribed medicines to treat high blood pressure and heart failure, the number of reviews overdue had been reduced from 138 in April 2022 to 51 in October 2022. However, systems to ensure all patients requiring a review, were not fully embedded. For example:	

- We reviewed 5 out of 33 patients prescribed potassium sparing diuretics (a medication used to treat high blood pressure and certain heart conditions) who had not received necessary monitoring. One patient identified had not been included on the practice's registers and had not been recalled for a review since 2012. Another patient had been inappropriately referred to the district nurses to have their blood test done, which was not in their operational remit and the referral had been subsequently rejected. Three patients had or were in the process of receiving necessary blood tests.

There was a backlog of approximately 1800 unfiled documents dating back to 6 October 2022. Staff told us that all documents that were received by the practice were scanned on to the system on a daily basis, however staffing shortages had contributed towards this backlog. The practice were looking at training up an additional member of staff to assist.

The practice did not regularly monitor their coding and workflow team to ensure appropriate codes were applied to records or that information received from third parties was reviewed as necessary. We were told that quality audits were conducted on particular codes or document type if a concern or problem was identified but regular monitoring of individual work was not conducted. The practice had a coding guide which gave guidance to staff on what codes to apply to records in response to documents received. However, the document did not specify which conditions required clinical review to ensure patients' care and treatment was assessed appropriately.

Housebound patients did not always receive a review of their care and treatment. We reviewed patients diagnosed with asthma prescribed 12 or more inhalers for exacerbations in their condition in the last 12 months. We found that patients who were housebound had not had their care and treatment reviewed due to staffing issues.

The practice had moved to a fully triaged on-the-day appointment system for patients requesting a GP appointment. Patients would be put on a telephone triage list and would receive a call from a GP to determine care and treatment needs. If a face to face appointment was required, they would be booked in with a primary care practitioner (PCP) in their acute care team or the duty GP. The practice did not have an agreed scope of practice demonstrating what conditions or patient groups were appropriate for PCPs to manage and what required GP intervention. Feedback from staff included that patients had been booked in for appointments when they were not always comfortable or confident in dealing with the concern. A supervising GP was assigned daily to support the team however feedback from staff was mixed about the level of support they received. Feedback included the level of support and the ability to transfer the patient to a more appropriate clinician, would depend on which clinician was supervising.

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.

- Staff told us that they had not restarted offering annual health checks for patients over 75 as they were still working their way through the backlog of long term condition reviews. However, they would conduct a health check if specifically requested by a patient.

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were offered a structured 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	74	88	84.1%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	80	88	90.9%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	79	88	89.8%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	79	88	89.8%	Below 90% minimum

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	106	116	91.4%	Met 90% minimum
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

### Any additional evidence or comments

Immunisation clinics were held 1 morning a week and staff told us they would encourage patients to attend for immunisations during this clinic. They told us that under special circumstances, they may arrange for patients to attend for immunisations on alternative days but it was not routine to offer this if patients found it difficult to attend. Patients who did not attend for their appointment were not always followed up by the practice. Staff told us that they would try and text or call patients but due to staffing shortages, this did not always happen. Meeting minutes demonstrated that there had been a high number of patients who did not attend (DNA) for their appointment. In response, the practice identified that they would publish the number of patients who DNA appointments on their website to demonstrate the impact. One member of staff told us they had begun booking the next appointment when children were brought for their immunisations which had helped improve uptake.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	63.8%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	72.1%	59.0%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	67.9%	70.9%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	48.2%	56.6%	55.4%	No statistical variation

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.

### Any additional evidence or comments

The practice had not identified actions to improve uptake of cervical screening. Feedback from staff included that they were unaware of patient uptake and that it had not been discussed in relevant team meetings.

### Monitoring care and treatment

**The practice had a 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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Partial
Explanation of any answers and additional evidence: The backlog of unfiled documents and lack of monitoring of the practice's coding team, meant the practice were unable to provide assurances that unplanned admissions and readmissions were reviewed in a timely way by an appropriate person.	

**Effective staffing**

**The practice was unable to demonstrate that all 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.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Yes
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.	No
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: The practice was unable to provide assurance that all staff had the knowledge and experience to deliver effective care and treatment. The practice had not assessed the competence of their primary care practitioners (PCPs) and no limitations were placed on their scope of practice. Feedback included that staff had previously held different healthcare roles such as nurses and paramedics, which meant training and expertise varied. Following inspection, the practice sent us an action plan which identified the need to devise a skills matrix for PCPs, however timescales for this had not yet been agreed.  The practice had not monitored the competence of staff employed in advanced clinical practice. The practice employed 2 non-medical prescribers. However, the practice had not conducted any quality assurance activity to ensure they acted in their own competencies and that patient outcomes and	

medicines prescribed were appropriate. Following inspection the practice sent us an audit template for prescriptions issued.

The practice told us staff had protected time to complete mandatory training and training for continued professional development. However, feedback from staff included that they were not always given the time away from practice to complete mandatory training or attend external training events. Staff training records identified that mandatory training including basic life support, safeguarding and fire prevention, was not up to date.

The practice had not ensured all staff had access to regular appraisals or supervisions. Staff we spoke with who had started work at the practice in the last 2 years had not received an appraisal.

### Coordinating care and treatment

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

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

### 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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

### 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.	Yes

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed patient records where a DNACPR decision had been recorded. We identified that, where possible, patients views had been sought and respected. We saw that information had been shared with relevant agencies.</p>	



## Responsive

## Inspected but not rated

### Access to the service

#### People were not 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 minimize 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)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence: The practice was unable to give assurances that patients would receive continuity of care for wound management as they did not have the staffing capacity to hold their own wound clinics. If patients required routine dressings, appointments were scheduled where possible. However, if patients required urgent wound dressings, the practice told us they would be referred back to secondary care.	

## Well-led

## Rating: Requires Improvement

We rated the practice as requires improvement for providing well led services because:

- The overall governance arrangements were not always effective.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- Feedback from staff included that support among staff groups was not always equal and communication was not always effective.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: We identified there was a disparity of information between staff and managers. For example, feedback from staff included that the practice were recruiting additional staff to assist with patient demand. However, practice managers told us that other than GPs, there were no other staff vacancies.	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The practice had become an employee owned trust (EOT) in July 2022. This decision was made in consultation with practice staff following the retirement of GP partners. There was a board of trustees which consisted of 1 member from each staff group and they held the company directors to account. However, feedback from staff included that they felt the full financial implications of moving to an EOT were not made clear and that recent changes were not always communicated effectively.	

### 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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	No
Explanation of any answers and additional evidence: Practice training records identified 40 out of 51 members of staff had not completed or were up to date with equality and diversity training.	

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

Source	Feedback
CQC inspection	Feedback from staff included they could raise concerns when this went wrong but that support received by staff was not always equal and that recent changes had been challenging and not always communicated well.
CQC remote interviews	Feedback included that staff felt comfortable in raising concerns when things went wrong but that communication from senior leaders could improve.

#### Governance arrangements

#### The overall governance arrangements were not always effective.

	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.	Partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Partial
Explanation of any answers and additional evidence: Practice safeguarding processes were not embedded and had not been formalised to ensure consistency. The practice did not have effective oversight of staff training and were unable to demonstrate what level of safeguarding training staff had received. Feedback from staff, including clinical staff, indicated that training had not been completed in line with national guidelines.  Systems to maintain oversight of practice processes were not always effective. For example: <ul style="list-style-type: none"> <li>• The practice had not monitored staff immunisation status, including clinical staff employed in the previous two years.</li> <li>• Employment records did not always contain necessary information.</li> <li>• The practice had not ensured staff were given the necessary time to complete tasks associated with additional lead roles.</li> </ul>	

There were not always appropriate systems to identify and manage backlogs. The practice had a backlog of approximately 1800 unfiled documents and had not implemented an action plan to address this.

## Managing risks, issues and performance

### The practice did not 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.	Partial
There were processes to manage performance.	No
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

#### Explanation of any answers and additional evidence:

Systems weren't operated effectively to ensure all patients received routine monitoring and prescribing practices remained appropriate and in line with guidance. For example:

- Medicine reviews did not always contain necessary information including a rationale for continued prescribing.
- Not all patients diagnosed with hypothyroidism or prescribed potassium sparing diuretics, had received a review or had been recalled as necessary.
- Not all patients who were housebound had received a review of their care and treatment.
- Not all patients affected by safety alerts had their care and treatment reviewed.

There wasn't effective oversight to ensure all risks were formally assessed or that risk assessments conducted appropriately identified areas of concern. For example:

- The practice had not formally assessed the impact staff not receiving DBS checks until after their induction.
- Risk assessments had not identified inconsistencies in fire safety and Legionella procedures.
- The practice had not assessed the impact of not holding all recommended emergency medicines and equipment.

Practice systems had not ensured patient group directions had been authorised in line with guidance.

Oversight of staff training was not effective. Not all staff had completed or were up to date with mandatory training. The practice told us training requirements were discussed at the beginning of team meetings but this had not been documented and training records demonstrated that this had not been effective in ensuring training was completed or up to date.

The practice did not have effective systems to ensure staff performance was monitored appropriately. For example:

- Not all staff had received an appraisal including clinical staff.

- The practice did not have a scope of practice for staff employed as primary care practitioners and had not monitored their consultations to ensure patient outcomes were appropriate.
- There was not a process to support regular monitoring of the practice's coding team to ensure accuracy.

In response to patient demand, the practice had moved to a fully triaged appointment system for patients requesting GP appointments.

### Appropriate and accurate information

#### The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: The practice was unable to demonstrate that performance data was always shared with relevant teams or that actions had been identified to improve uptake of health screenings in line with national targets. However, staff told us that they did receive feedback on their antimicrobial prescribing.	

### 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.	Yes
The practice had an active Patient Participation Group.	Yes
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.	Yes
Explanation of any answers and additional evidence: The practice had the chair from their patient participation group attend trustee meetings so that the patient perspective could be taken into account when changes to the service were discussed.  Feedback from staff included that different teams in the practice could feel segregated and that suggestions to help improve this were only just being listened to. For example, suggestions to combine team meetings for staff groups which worked closely together, had just been implemented despite it being raised previously by staff.	

### Continuous improvement and innovation

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

	Y/N/Partial
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There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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