

Care Quality Commission

Inspection Evidence Table

Brunswick Surgery (1-2478073980)

Inspection date: 14 December 2022

Date of data download: 12 December 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

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

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

| Recruitment systems | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Y |
| Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role. | Y |
| | |

| Safety systems and records | Y/N/Partial |
|----------------------------|-------------|
|----------------------------|-------------|

| | |
|--|---|
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 1/11/22 | Y |
| There was a fire procedure. Date of fire risk assessment: 8/12/21 | Y |
| Actions from fire risk assessment were identified and completed. | Y |
| | |

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|-------------|
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 29/4/22 | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| | |

Risks to patients

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

| | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods. | Y |
| There was an effective induction system for temporary staff tailored to their role. | Y |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Y |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Y |
| There were enough staff to provide appointments and prevent staff from working excessive hours | Y |
| | |

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. ¹ | Y |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Y |

| | |
|--|---|
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Y |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Y |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Y |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Y |
| Explanation of any answers and additional evidence: Review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance. | |

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 average | England comparison |
|--|----------|---------------|-----------------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA) | 0.84 | 0.69 | 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). (01/10/2021 to 30/09/2022) (NHSBSA) | 9.2% | 8.7% | 8.5% | 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 (01/04/2022 to 30/09/2022) (NHSBSA) | 5.07 | 5.48 | 5.28 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 39.7‰ | 60.6‰ | 128.0‰ | Variation (positive) |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group | 0.61 | 0.53 | 0.58 | No statistical variation |

| Indicator | Practice | SICBL average | England average | England comparison |
|---|----------|---------------|-----------------|--------------------------|
| Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small> | | | | |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small> | 4.7‰ | 4.8‰ | 6.7‰ | 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. ¹ | Y |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Y |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ² | Y |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | Y |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Y |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective. | Y |

| | |
|-----------------------------|--------------------|
| Medicines management | Y/N/Partial |
| | |

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong

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

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

| Event | Specific action taken |
|---|--|
| Patient found unconscious outside of premises. | Reception will risk assess patients before sending them out of the practice to enter a different entrance. |
| A patient was given a vaccination at the wrong time | A new process and system was implemented to check and recheck the time period three times. |

| Safety alerts | Y/N/Partial |
|--|--------------------|
| There was a system for recording and acting on safety alerts. ¹ | Y |
| Staff understood how to deal with alerts. | Y |
| Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts, for example, regarding sodium valproate. | |

Effective

Rating: Good

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

| | Y/N/Partial |
|---|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹ | Y |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ² | Y |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Y |
| Patients' treatment was regularly reviewed and updated. ³ | Y |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |
| The practice prioritised care for their most clinically vulnerable patients. | Y |
| | |

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

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

| 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) (UKHSA COVER team) | 79 | 84 | 94.0% | Met 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (UKHSA COVER team) | 83 | 99 | 83.8% | Below 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) (UKHSA COVER team) | 84 | 99 | 84.8% | Below 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, | 86 | 99 | 86.9% | Below 90% minimum |

| | | | | |
|--|----|----|-------|------------------|
| mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team) | | | | |
| 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) (UKHSA COVER team) | 69 | 97 | 71.1% | 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

The practice had a system to improve its statistics for child immunisation. The nurse maintained a log of all children who required vaccination. All children were texted and called to arrange appointments. If they didn't engage or attend then they were referred to the health visitor. This system was clear and in progress at the time of the inspection. One challenge this practice had was that many patients travelled abroad with children and so their schedules did not line up with vaccination timelines.

| 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) | 75.0% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA) | 67.8% | 52.3% | 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) | 70.8% | 63.5% | 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) | 65.7% | 52.8% | 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 a system to improve its statistics for cancer screening. The nurse maintained a log of all people who required screening. She routinely texted and called all these patients to arrange appointments.

Monitoring care and treatment

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

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

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

An audit of patients with chronic kidney disease found multiple gaps with patients who had not had sufficient monitoring. As a result of this audit the practice implemented instant text messages for patients who required monitoring which were followed up with letters for patients who were diagnosed based on test results. The practice also implemented urinary tests for these patients and repeated this audit cycle every three months. The audit had already resulted in improved patient numbers for monitoring and diagnosis.

Effective staffing

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

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

Coordinating care and treatment

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

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

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 |
| | |

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. ¹ | Y |
| Explanation of any answers and additional evidence, including from clinical searches: Our clinical review of notes where a DNACPR decision had been recorded identified that where possible the patients views had been sought and respected. We saw that information had been shared with relevant agencies. | |

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

| | Y/N/Partial |
|---|-------------|
| Staff understood and respected the personal, cultural, social and religious needs of patients. | Y |
| Staff displayed understanding and a non-judgemental attitude towards patients. | Y |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Y |
| | |

| Patient feedback | |
|---------------------------|--|
| Source | Feedback |
| Friends and Family survey | Patients had made positive feedback overall through this survey method which showed 90% of patients were happy with the practice |
| NHS Choices | Two patients left positive reviews stating that the practice was efficient |
| | |

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 average | England comparison |
|---|----------|---------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022) | 90.5% | 86.4% | 84.7% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022) | 89.7% | 84.8% | 83.5% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022) | 95.1% | 94.0% | 93.1% | No statistical variation |

| Indicator | Practice | SICBL average | England average | England comparison |
|---|----------|---------------|-----------------|--------------------------------------|
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022) | 90.0% | 77.0% | 72.4% | Tending towards variation (positive) |

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

Involvement in decisions about care and treatment

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

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

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 average | England comparison |
|--|----------|---------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022) | 94.8% | 90.8% | 89.9% | No statistical variation |

| | Y/N/Partial |
|---|-------------|
| Interpretation services were available for patients who did not have English as a first language. | Y |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Y |

| | |
|---|---|
| Information leaflets were available in other languages and in easy read format. | Y |
| Information about support groups was available on the practice website. | Y |
| | |

| Carers | Narrative |
|---|--|
| Percentage and number of carers identified. | 116 which is 1% |
| How the practice supported carers (including young carers). | The practice had a dedicated employee for carers. Annual contact was made to inform them of services available. Social Prescribers all offered support to carers as well. Kingston Carers network was contacted and work was planned out with them just before the pandemic. The practice always prioritised their appointments. All carers were recorded with alerts and clearly coded on the system. |
| How the practice supported recently bereaved patients. | The practice sends out cards to all bereaved patients which includes details of all available services for them to seek support with. The GPs call the patients as well to see if they need or want anything they can help with. |

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs

| | Y/N/Partial |
|--|-------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | Y |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Y |
| The facilities and premises were appropriate for the services being delivered. | Y |
| The practice made reasonable adjustments when patients found it hard to access services. | Y |
| There were arrangements in place for people who need translation services. | Y |
| The practice complied with the Accessible Information Standard. | Y |
| | |

Practice Opening Times

| Day | Time |
|----------------|---------------|
| Opening times: | |
| Monday | 08:00 - 18:30 |
| Tuesday | 08:00 - 18:30 |
| Wednesday | 08:00 - 18:30 |
| Thursday | 08:00 - 18:30 |
| Friday | 08:00 - 18:30 |
| | |

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

| | Y/N/Partial |
|--|-------------|
| Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice | Y |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online) | Y |
| Patients were able to make appointments in a way which met their needs | Y |
| There were systems in place to support patients who face communication barriers to access treatment (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 |
| | |

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 average | England comparison |
|---|----------|---------------|-----------------|----------------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022) | 83.8% | N/A | 52.7% | Significant Variation (positive) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022) | 74.8% | 61.1% | 56.2% | No statistical variation |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022) | 69.2% | 60.1% | 55.2% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022) | 71.5% | 72.5% | 71.9% | No statistical variation |

| Source | Feedback |
|--------------------------|---|
| For example, NHS Choices | There were two positive reviews and one negative review. The practice had responded to and engaged with all online reviews. |

Listening and learning from concerns and complaints

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

| Complaints | |
|--|----|
| Number of complaints received in the last year. | 10 |
| Number of complaints we examined. | 3 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 3 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

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

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|--|---|
| An address change was not recorded at the practice for a patient | The practice contacted the patient to resolve the issue and apologise for the mistake. Addresses will be checked by administrators to prevent the mistake being made in the future. |
| A patient complained about a diagnosis issue | The complaint was thoroughly investigated by the practice and the patient was written to in detail. The outcome was a matter of clinical decision making and no fault or mistake had been made. |

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

| | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |
| | |

Vision and strategy

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

| | Y/N/Partial |
|---|-------------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Y |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Y |
| Progress against delivery of the strategy was monitored. | Y |
| | |

Culture

The practice had a culture which drove high quality sustainable care

| | Y/N/Partial |
|---|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Y |
| Staff reported that they felt able to raise concerns without fear of retribution. | Y |
| There was a strong emphasis on the safety and well-being of staff. | Y |
| There were systems to ensure compliance with the requirements of the duty of candour. | Y |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | Y |
| The practice encouraged candour, openness and honesty. | Y |
| The practice had access to a Freedom to Speak Up Guardian. | Y |
| Staff had undertaken equality and diversity training. | Y |
| | |

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

| Source | Feedback |
|-----------------------|---|
| Interviews with Staff | We spoke to staff at the practice who told us that they were happy working with the team who were supportive and efficient. Staff said the management team were good as they always interacted with the entire staff team and offered strong support throughout the practice. |

Governance arrangements

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

| | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed. | Y |
| Staff were clear about their roles and responsibilities. | Y |
| There were appropriate governance arrangements with third parties. | Y |
| There are recovery plans in place to manage backlogs of activity and delays to treatment. | Y |
| | |

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

| | Y/N/Partial |
|--|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Y |
| There were processes to manage performance. | Y |
| There was a quality improvement programme in place. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| | |

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making

| | Y/N/Partial |
|---|-------------|
| Staff used data to monitor and improve performance. | Y |
| Performance information was used to hold staff and management to account. | Y |
| Staff whose responsibilities included making statutory notifications understood what this entailed. | Y |
| | |

Governance and oversight of remote services

| | Y/N/Partial |
|---|-------------|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y |
| The provider was registered as a data controller with the Information Commissioner's Office. | Y |
| Patient records were held in line with guidance and requirements. | Y |
| Patients were informed and consent obtained if interactions were recorded. | Y |
| The practice ensured patients were informed how their records were stored and managed. | Y |
| Patients were made aware of the information sharing protocol before online services were delivered. | Y |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Y |
| Online consultations took place in appropriate environments to ensure confidentiality. | Y |
| The practice advised patients on how to protect their online information. | Y |
| Staff are supported to work remotely where applicable. | Y |
| | |

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

| | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture. | Y |
| The practice had an active Patient Participation Group. | Y |
| Staff views were reflected in the planning and delivery of services. | Y |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y |
| | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| The PPG had last met on 8/4/22 and had given feedback on the practice website concerning the forms being used for triage. The forms were not user friendly and could be altered to be easier to use for patients. The practice altered the forms that same day accordingly to as to improve their ability to triage patients and enable easier use of the forms for patients. |

Continuous improvement and innovation

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

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

Examples of continuous learning and improvement

The practice was using one system for digital appointments which was not enabling patients to order repeat prescriptions. Staff and patients fed this information back to the practice and a new system was installed within months of the feedback. Staff and patients then commented that the new system being used by the practice had enabled repeat prescriptions to be ordered easily and it made the entire process more efficient for patients.

The practice created an audit to consider patients with mental health concerns who were also on the gun license register. This enabled the practice to risk assess these patients and consider any dangers they may pose. The outcome was that no patients with mental health concerns were on the register.

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) | ≤ -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 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.