

Inspection Evidence Table

ISSA Medical Centre - Dr Z H Patel (1-541838559)

Inspection Date: 18 July and 10 August 2023

Date of data download: 19/07/2023

Overall rating: Good

At the last inspection on 5 and 6 April 2022 we rated the key questions safe, effective and well led as requires improvement. At this inspection we found that those areas previously highlighted as requiring improvement had been addressed. Therefore, the practice is now rated as good overall.

Safe

Rating: Good

At this inspection, we found that those areas previously regarded as requiring improvement had shown improvement. The practice is therefore now rated as good for providing safe services.

Safety systems and processes

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

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

Explanation of any answers and additional evidence:

- The practice had two organisational leads for safeguarding these were general practice doctors located at Deepdale and Fulwood. They were responsible for all safeguarding matters.
- We observed that children subject to safeguarding concerns or child protection issues and adults who were at risk or vulnerable were coded on their electronic records. An alert appeared on screen when accessing such records which prompted the user and made them aware of the risks. We saw evidence that all relevant alerts were in place and followed best practice.
- We saw evidence that multi-disciplinary team (MDT) meetings around safeguarding took place. These included a range of health professionals such as representatives from safeguarding teams, social services, palliative care teams, community matron and district nurses.
- Clinicians followed up on children and young people who did not attend appointments both at the practice and for secondary care appointments.
- We saw that staff meetings and clinical meetings had taken place and all had an agenda and minutes were recorded and shared. We saw that safeguarding was discussed during such meetings and key information was shared with staff.
- The staff we spoke with understood their responsibilities around safeguarding and could explain what they would do if any concerns became apparent. Clinical staff were trained to level 3 and leads were trained to level 4 in safeguarding in keeping with recommendations and guidance.
- Staff were all signed up to the annual DBS update scheme and had up to date checks in place.
- Safeguarding policies were in place and reviewed regularly and were available on the practice electronic systems for all staff. Procedures, key information and telephone numbers were kept in hard copy form and were found on noticeboards and in prominent places.

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

Explanation of any answers and additional evidence:

- The sample of employment recruitment files checked showed evidence that the practice were compliant with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This describes checks needed for persons employed for the purposes of regulated activity.
- The practice recruitment policy did not include details of all the checks required and the rationale behind them under the regulations, we were advised that this would be reviewed immediately to reflect the required checks.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 14.11.22 (Fulwood), 04/01/23 (Deepdale)	Y
There was a fire procedure.	Y

Date of fire risk assessment: 20/07/2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection we found limitations in the effectiveness of the health and safety risk assessment. At this inspection we found this had been improved and issues identified were followed up with action plans to rectify and address the matters highlighted. All electrical and clinical equipment at both sites had been checked and calibrated to ensure it was safe to use and was in good working order. Checks on fire extinguishers, smoke alarms, intruder alarms and water quality were completed and documented effectively. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 27.07.2023 (Fulwood), 03.08.2023 (Deepdale)	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection we found issues with the practice infection and control policy. At this inspection we saw that a new policy had been implemented which ensured that staff understood their responsibilities around infection prevention and control. At the previous inspection we found limitations in the previous infection prevention and control audit. At this inspection we found that the processes had been improved and it was more comprehensive. The audit now covered all relevant areas. We also found that action plans were established which were designated to a responsible individual and actions were closed when they had been completed. Observational hand hygiene audits were completed and documented. The infection prevention and control lead was the practice nurse. She was supported by a two health care assistants in this role. Stocks of personal protective equipment (PPE) was readily available and staff followed the most up to date guidance in relation to minimising risks of cross infection. The environment appeared clean and tidy and free from clutter. In the event of a spillage reception and other staff used the spill kit on site. Staff we spoke with were familiar with its use. Individual practitioners were responsible for ensuring the environment was clean between patient use, such as replacing blue paper role on examination couches, wiping surfaces and equipment. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• At the previous inspection, there was only 1 nurse who was qualified to undertake cervical screening. At this inspection we found that additional staff had been recruited and trained which meant that staff were not required to work excessive hours and the responsibilities were shared amongst 5 staff members.• Additional staff had also been recruited to key positions enabling greater flexibility and support for all staff.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• At the previous inspection we found there were gaps in documentation and recording of the blood tests undertaken in connection with the monitoring of high-risk medicines. At this inspection we found this had improved and that there was a record that tests had been conducted and the result recorded to show it was safe to continue to prescribe high risk medications.	

- At the previous inspection we found that legacy Medicines and Healthcare products Regulatory Agency (MHRA) alerts were not being routinely audited. At this inspection we found that these had now been established into a regular audit programme.
- At the previous inspection we found that some patients had not been coded as diabetics appropriately. At this inspection we found this had improved. However, it would be difficult for the practice to confirm or rule out their diagnosis as they were not undertaking checks at the recommended intervals which would confirm or rule out a diagnosis of diabetes more effectively.
- The practice had a system for monitoring patients on the urgent pathway. These referrals were appropriately managed. Administrators had responsibility for logging all referrals and they kept records to ensure these were followed up. A system was in place to ensure urgent appointments were received and secondary care providers were contacted if a patient had not received an appointment within the expected timescale.

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	1.36	1.15	0.91	Variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) (NHSBSA)	7.4%	7.9%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) (NHSBSA)	4.13	4.33	5.23	Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	154.5‰	144.3‰	129.8‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.58	0.41	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	6.9‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> As part of our inspection, we undertook a search and review of the practice's electronic patient records. We selected a sample of patient records to determine if the practice were following recommendations and best practice in relation to medicines management. We found that medicines management had improved since the last inspection and only minor issues were identified. The majority of these had been corrected before the end of the inspection. We found good management of patients on methotrexate (a medicine used to reduce activity of the immune system for people who have certain conditions). We noted that there was a need for the practice to ensure the day of the week the medication was taken by the patient was recorded. The practice advised us this had been put in place shortly after the inspection. 	

- We found good management of patients on potassium sparing diuretics (medicines that increases urine production and used for heart conditions), 6 of 133 patients had overdue monitoring and we saw attempts to gain compliance in these patients, some already had appointments booked.
- We found good management of patients on teratogenic medication (medicines that can cause birth defects). We sampled 5 out of the 118 patients on this medicine and found they had all been informed of the risks and birth control options had been discussed.
- We identified a patient on metformin (a medicine used to treat diabetes) and whose eGFR (a test to gauge kidney function) was less than 30. This was not in line with recommendations and was raised with the practice. We were advised that this would be reviewed and changed if necessary.
- The provider recorded medicine reviews had been conducted without documenting the outcomes from the review in 3 out of the 5 cases we examined. The practice stated they would use this as a learning point.
- At the previous inspection we found formalised systems to ensure the competence of staff employed in advanced clinical roles and non-medical prescribing had not been established. However, at this inspection we observed that a formal supervision process had been implemented. This involved random sampling of consultation and prescribing, and these were documented and recorded to provide assurance of oversight and the monitoring of competence.
- Similarly at the previous inspection we found the supervision of nurses and healthcare assistants was not in place. At this inspection we found effective systems were now in place, these were both formalised and documented.
- We found that there was a process for managing Medicines and Healthcare Products Regulatory Agency (MHRA) alerts.
- Emergency medicines were managed appropriately and checked to ensure they remained fit for use. Records were maintained on an online management application.
- Medical oxygen was maintained and stored appropriately, and weekly checks were completed.
- An emergency trolley was in-situ with appropriate equipment including a defibrillator which was checked regularly, and records maintained.
- The doctor's bag, which was used for home visits, and which contained medicines and perishable items, was stored securely and maintained appropriately. However, the contents were not initially recorded; this was raised with the practice, and this was immediately rectified and a list with contents and expiry dates was established.
- The medicines fridge temperature was monitored appropriately to ensure medicines stored were kept at the correct temperature to ensure they remained fit for use. Records were kept and staff were aware of what to do if the fridge temperature went out of safe vaccine storage range.
- Staff were trained and confident in understanding the maintenance of the cold chain involving vaccines.
- Patient group directions were in place for some vaccinations, these were in date and documented accurately.
- The sample of medicines we checked were stored appropriately and were in date.
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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: 91 (from June 2022 to July 2023)	Y
Number of events that required action: 91	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection we found that the incident reporting system could be improved. At this inspection we found that the process for recording and managing incidents had been developed and all issues addressed. A new incident reporting process had been introduced and more incidents had been captured. We reviewed a sample of the recorded incidents and found these had been documented and investigated appropriately. We also found that actions and outcomes from the investigations were followed up and documented in a way that demonstrated effective action and learning was achieved. Staff we spoke with were aware of incidents that had occurred and were able to tell us about the learning from these. We saw that incidents and events were discussed during clinical and team meetings. 	

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

Event	Specific action taken
Blood test results written down incorrectly when pathology telephoned with results.	Pathology calls now only taken by the reception supervisors and managers, blood test results to be read back to the caller to verify they are correct.
Out of date vaccine found in the fridge.	Full investigation – greater security for fridges, enhanced monitoring of vaccine stock, expiry dates and stock numbers.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw examples of actions taken on recent alerts, for example the practice undertook an audit of patients aged 65 years and over and taking citalopram or escitalopram (medication for depression). They sought to reduce the dosage of the medication to reduce the risks identified by the MHRA safety alert. We saw that the practice regularly undertook audits and ran searches for high-risk medication and MHRA safety alerts to identify patients at risk and ensure recommendations were followed. Our search of the practice clinical system found good compliance with the recommendations and an improvement since the previous inspection. 	

Effective

Rating: Good

At this inspection, we found that those areas previously regarded as requiring improvement had shown improvement. The practice is therefore now rated as good for providing effective services.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• We found that patients records had the appropriate alerts in place to identify and advise staff that a patient may be vulnerable. The practice maintained registers of vulnerable persons and we observed that these were coded on the electronic patient record and a note appeared on screen when accessing them. This prompted the user to make them aware of the risks.• We saw that regular, documented discussions around safeguarding took place. We saw evidence of MDT meetings with other practices and a range of health professionals such as representatives from safeguarding teams, social services, palliative care teams, community matron and district nurses.• We saw that staff team meetings and clinical meetings had taken place and had an agenda and minutes were recorded and shared. We saw that safeguarding was discussed during these meetings and key information was shared with staff.	

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.
- Vulnerable patients were offered same day appointments with named GP where possible.
- 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.
- 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.
- The practice assessed and monitored the physical health of people living with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services. Those identified received a full assessment of their physical, mental and social needs.
- The practice had access to mental health practitioners, psychological practitioners, child and young person's mental health nurse.
- All patients with a learning disability were offered an annual health check.
- Patients living in care homes or nursing homes were assisted by a dedicated care home team, ward rounds were in place, and they received an annual review and review within 3 days if they had spent time in hospital.
- A step-down team supported patients who were receiving rehabilitation in the community to try to prevent readmission and enable them to return home.

Management of people with long term conditions

Findings

- We found a good standard of annual review were documented for patients with diabetic retinopathy (an eye condition that can cause vision loss and blindness in people who have diabetes) who's latest HbA1c (a blood test used to estimate control of diabetes) was greater than 74mmol/l. However, we also found that medication reviews were coded as having been completed but no narrative was documented to describe what had taken place.
- We found good management of patients with chronic kidney disease stage 4 and 5 (significant impairment of kidney function), 1 patient from 134 patients had overdue monitoring.
- We found good management of patients with hypothyroidism (low thyroid hormones), 2 patients from 916 had overdue monitoring and we saw multiple attempts to encourage them to attend.
- We examined patient records for patients who may have had a potential missed diagnosis of diabetes. 28 patients were identified in the search. We reviewed 5 of those records in greater detail. We found that although the management of these patients was satisfactory, we identified that timing of follow up intervals was not always in line with recommendations making confirming or dismissing a diabetes diagnosis unreliable.
- We examined the records of patients who had been prescribed 2 or more doses of prednisolone (a steroid and anti-inflammatory medicine) for an acute exacerbation of asthma. In 2 out of 3 records we examined in more detail, we found there were no clinical notes documented to support the decision to prescribe the

medicine, nor were steroid cards issued. The third did not have the expected review to follow up their response to the treatment. However, we found annual asthma reviews were well recorded. We raised this with the practice who stated those cases would be reviewed and updated appropriately.

- Chronic disease registers were maintained to help with oversight and management of these cohorts of patients.
- 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.
- A GP with special interest in diabetes supported the management of patients with complex diabetes. They also supported the practice team with education and expertise in diabetes management. The practice also employed a diabetes specialist nurse.
- The practice employed a respiratory specialist nurse who supported patients with respiratory conditions, they could complete spirometry and FeNO measurements (tests to monitor respiratory conditions) on site for patients.
- The practice offered onsite international normalised ratio (INR) blood tests for those with blood clotting disorders.
- Patients with multiple long-term conditions were offered combined reviews where possible to prevent the need for multiple reviews being undertaken separately.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- The practice had access to social prescribers who could signpost alternative sources of support for those living with long term conditions.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	339	371	91.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	350	401	87.3%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	350	401	87.3%	Below 90% minimum

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	351	401	87.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	326	408	79.9%	Below 80% uptake

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

Any additional evidence or comments
<ul style="list-style-type: none"> The practice leaders explained the challenges they experienced due to the demographics of the patients using the practice. Some were reluctant to have childhood vaccinations due to cultural or religious beliefs. Others had different beliefs regarding the ages at which their children should be immunised. This meant that some children had not been brought by the parents and caregivers for vaccination. The practice had tried different strategies to try and increase the uptake of child immunisations. This included education on the benefits and an understanding of what the vaccination procedure entails and what the actual vaccine was composed of. This was to support the understanding of patients and allay fears about vaccinations to increase uptake. The practice offered a range of vaccination appointments at different times and days to offer maximum flexibility for patients. Any patients that missed appointments were contacted to understand why the appointment was missed. They were offered a conversation with a clinician if they wanted and given education and advice in order to encourage their compliance. The practice had undertaken educational sessions for hard to reach groups to promote the benefits of immunisation and dispel fears at key community settings to try to encourage the take up.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	31.1%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	56.3%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot 31/12/2022) (UKHSA)	53.6%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	57.8%	58.7%	54.9%	No statistical variation

Any additional evidence or comments

- At the previous inspection we identified issues regarding the practice's ability to deliver their cervical screening programme due to staffing issues. We found that on this inspection this had improved.
- The practice had recruited and trained additional staff who could undertake cervical screening. They had increased the number of cervical screening appointments they were able to undertake.
- The practice leaders explained the challenges they experienced due to the demographics of the patients using the practice. Some were reluctant to attend screening due to cultural or religious beliefs. Others had poor health literacy and did not understand or accept the benefits of screening. This meant that there were challenges around achieving uptake targets.
- The practice offered a range of screening and testing appointments. These were also available outside core hours such as evenings and weekends to offer maximum flexibility for patients.
- The practice had undertaken educational sessions for hard to reach groups to promote the benefits of immunisation and dispel fears at key community settings to try to encourage the take up.
- The practice provided unvalidated data which was more recent than the data above which showed they had achieved an improvement since the last inspection with their cervical screening uptake. This unvalidated data showed that 67% of relevant persons aged 25 to 49 years had been screened in the last 3 years and 6 months and 82% aged 50-64 years had been screened in the last 5 years and 6 months.

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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> • A clinical audit was undertaken looking at patients of child-bearing age on valproate, carbimazole and modafinil medicines. This review provided assurance that patients were aware of the risks of these medications and were able to make informed choices or family planning and whether they wanted to continue to receive the medicines or not. • Improvements in support and oversight of staff since the last inspection had led to staff reporting they felt supported, and were developing in confidence and capability. • The practice listened to patient feedback around telephone access. They introduced a new telephone system that had enabled them to respond to peaks in demand and understand where they needed to increase resources. This had led to a demonstrable reduction in the time patients wait for their call to be answered and increased patient satisfaction as evidenced by data analysis and patient surveys. Following the installation of the new phone system which could produce a wealth of data such as numbers and times of calls, call waiting times, abandoned calls and repeated calls. The practice analysed this in detail and determined they could improve their response times further but that more line capacity was needed. They had commissioned new lines which were to be installed post inspection. 	

Any additional evidence or comments

- At the previous inspection we found performance monitoring and quality improvement initiatives were ad hoc and reactive. At this inspection we found significant improvement, and this had brought about a noticeable improvement in quality and performance as indicated by the clinical records searches.
- An annual audit programme was now in place and there was evidence of improvements based on national and local quality improvement initiatives.
- Audits had clear action plans and identified what action was needed to resolve or improve any issue identified.
- The practice had a programme of targeted quality improvement, this included patient feedback, looking at complaints and concerns and incident investigation alongside quality measurement and audits. These provided a comprehensive quality assurance and improvement programme.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At the previous inspection we found issues with the monitoring of clinical competence by the practice. At this inspection we found that effective supervision and monitoring was now in place. We saw that appropriate responsibility was given to appropriate and senior staff and they oversaw and documented the support provided. This was a blended approach which included one to one supervision, random sampling and checking of consultations and prescribing and group sessions with other staff. This was all documented to provide assurance. Staff we spoke with told us how constructive and beneficial this approach was and how it aided their development and safety of their work. • Similarly, nurses, assistant practitioners and health care assistants were also supported in their development and the practice was able to evidence how they maintained assurance and oversight of staff. • The practice also maintained oversight of administrative staff including those who had responsibility for clinical records and scanning. Supervisors undertook random sample checking of such records to ensure they were being dealt with appropriately. If they noted anything that could be done better, this was shared 	

with staff so improvements could be made. Listening in to receptionists' telephone calls also provided assurance that telephone calls were being managed appropriately.

- The practice kept clear and up to date records of staff training and competence to ensure they were deployed in appropriate areas to match their competence experience and training. This information was also used to identify areas which could be strengthened by recruitment of staff with particular skills.

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice was a key member of the local Primary Care Network (PCN), GPs and the practice managers had attended meetings with other PCN members to share information and support each other. There was a recognition of the value of this arrangement and the practice had received and provided support within the network. • The practice had access to the services of a trainee associate psychological practitioner, social prescribing link practitioner, first contact physiotherapist practitioner and mental health practitioner through its collaboration with the PCN. • The practice worked together with another local practice to provide extended hours appointments. These could be booked directly by reception staff. • Multidisciplinary and multi-agency working was evident from records and discussions with staff. • The service had good working relationships with others in the healthcare system such as district nurses, other practices in the PCN and secondary care providers. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y

Explanation of any answers and additional evidence:

- A social prescribing link practitioner obtained through an arrangement with the local PCN attended the Issa @ Deepdale and Issa @ Fulwood for 1 day per week to support patients with alternative sources of support, help and wellbeing options.
- Lifestyle advice and educational materials were available on noticeboards, in leaflets in the practice and on the practice website.
- Where appropriate the practice nurses provided support and advice around long term conditions when undertaking their long-term conditions reviews. Where patients experienced multiple conditions they were offered extended appointments to ensure a thorough review.
- Links to available online guidance could be sent via messages to the patient's smartphone. Or alternatively leaflets could be supplied.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The sample of 5 DNACPR records we examined demonstrated that records were completed appropriately. However, in 1 case there was no evidence of the appropriate discussion with the patient or their relative, there was also no reference to a best interest decision and consideration of mental capacity. This was highlighted to the practice who obtained the necessary documentation immediately. • An alert was present on electronic records to highlight that a DNACPR was in place. • A DNACPR annual audit was planned to keep oversight of DNACPRs in issue. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Friends and family test surveys in the vast majority of cases were positive. • SMS (text message) auto-polls were conducted to gain patient feedback. • The practice used the feedback and acted on this to improve the experience for patients and staff. • The National GP patient survey results had improved greatly since the last survey. • The practice had wellbeing and mental health practitioners within the service who could support patients holistically with their range of needs. 	

Patient feedback	
Source	Feedback
NHS GP patient survey.	Patient feedback and satisfaction levels were similar to local and national percentages.
CQC 'Give Feedback on Care'.	CQC received 600 pieces of feedback, 416 (69%) were positive, 162 (27%) were negative and 22 (4%) were mixed both positive and negative. The themes relevant to the caring key question provided some positive feedback about kind and attentive clinical staff, but that receptionists could be rude and unsympathetic.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 01/04/2023)	82.0%	86.5%	85.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 01/04/2023)	80.3%	84.2%	83.8%	No statistical variation

The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 01/04/2023)	91.5%	92.8%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 01/04/2023)	64.9%	74.5%	71.3%	No statistical variation

Any additional evidence or comments

- The practice undertook analysis of both their own patient surveys and the NHS national GP patient survey and tried to remedy the issues identified from the feedback. The 2022 survey provided some disappointing feedback, but the practice had introduced some measures identified from patient feedback to improve satisfaction levels. The latest (2023) survey results showed positive improvement and indicated the work they had done in this area had worked well.

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

Any additional evidence

- The practice collected feedback via friends and family text messaging service to gain feedback on how they were doing. This was analysed and action taken to improve the service where possible. This data was unvalidated but shows that they received 781 responses during June and July 2023, and it was reported that;
 - 580 (74%) rated the practice very good
 - 136 (17%) rated the practice good
 - 24 (3%) rated the practice neither good nor poor
 - 14 (2%) rated the practice poor
 - 3 (1%) rated them very poor
- In terms of recommending the practice to friends and family;
 - 673 (86%) said they would recommend
 - 56 (7%) said they would neither recommend or don't know
 - 39 (5%) said they would not recommend

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Easy read and accessible information was available. • The practice had a social prescriber who could signpost patients to appropriate assistance and community support. • Carers identified were contacted by the social prescriber and introduced to local carers centres. • Feedback from patients indicated they felt involved in decisions, for example a patient said the doctor was understanding and responsive to their preference of medication. 	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 01/04/2023)	85.6%	91.0%	90.3%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Information about support groups and alternative sources of support was available from the social prescriber, practice staff and displayed on posters in the practice. • The practice website was also had sources of information and support, education around health conditions and help with wellbeing and mental health. 	

Carers	Narrative
Percentage and number of carers identified.	The practice identified 1004 carers from their patient list; this equated to 3% of patients with caring responsibilities.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> • Access to social prescribing link practitioner. • Alert on patient record denoting person is a carer. • Signposted to carers centre.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> • Access to a mental health practitioners and associate psychological practitioners. • Signposted to community support providers.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Services were provided in a way that protected the privacy and dignity of patients. • The reception areas were large and spacious, waiting areas were far enough away so that conversations could not be overheard by waiting patients. • Staff had received training on information governance and General Data Protection Regulation (GDPR) principles around privacy and confidentiality. They were aware not to breach patients' privacy by disclosing information to others. 	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had listened to patients and sought their views over potential changes to the service. For example, the installation of a new telephone system. Following the installation they undertook a period of analysis of the data to understand call volumes, the patterns of such calls, calls abandoned and repeat calls. They targeted additional staff at busy points and further examined the data. They came to the conclusion that they also needed more telephone lines and have requisitioned these which were due to be completed shortly after the inspection. It was believed that this would improve access further and the practice would complete the same analyses to show continued improvement. They would also continue with their patient engagement to assess if the patients had benefitted from the change.• The practice had established a Patient Participation Group (PPG) who were able to provide input and for the practice to understand the needs of the population better. The PPG attracted a large number of members and this had fed into plans for future projects such as a wellbeing community garden project and ambitions to hold some key clinics in alternative venues such as community halls and religious centres.• Services were provided from a modern and well-maintained purpose-built building with on-site parking in pleasant surroundings.• The practice had access to translation services for those whose first language was not English.• A hearing loop was available in the practice.• The practice had processes in place for those patients who could not engage with the practice electronically, such as when ordering prescriptions or making an appointment.• The practice had undertaken the required training for learning disabilities. They had also undertaken other training for equality and diversity and dementia awareness.• The practice was wheelchair accessible.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 6pm (extended hours at PCN hub practice)
Tuesday	8am – 6pm (extended hours 6.00pm – 8.00pm)
Wednesday	8am – 6pm (extended hours 6.00pm – 8.00pm)
Thursday	8am – 6pm (extended hours 6.00pm – 8.00pm)
Friday	8am – 6pm (extended hours 6.00pm – 8.00pm)
Saturday	8am – 12pm (extended hours 9.00am – 5.00pm alternate Saturdays)
Out of Hours	NHS 111 and in collaboration with an external provider.

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

- The practice had established a pilot palliative care team which included a palliative care nurse specialist. They provided care planning and interventions for those needing palliative care and those approaching the end of their lives. This proved to be a very effective and well received service and the pilot was adopted by other providers using the practice’s model of care.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families’ wishes when bereavement occurred.
- The practice liaised regularly with other healthcare providers in their community services to discuss and manage the needs of patients with complex medical issues.
- Additional appointments were available outside of core hours for school age children and those of working age so that they did not need to miss school or work.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8pm on a Tuesday to Friday and on a Monday patients could access appointments at a neighbouring PCN practice. Appointments were pre-bookable and on the day appointments.
- Appointments were available Saturday 8am until 12pm and every other Saturday 9am until 5pm.

- 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 minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice offered a range of appointments including routine and pre-bookable as well as urgent appointments, both face to face and via the telephone. This was based on the patient's choice. • Patients were able to make an appointment via various methods; online, via the telephone and in person. • The practice had undertaken detailed analysis of their appointments system. They identified a demonstrable increase in appointments offered and available over the year prior to the inspection. This was achieved through the recruitment of additional and specialist staff and by referring patients to the best available clinician to meet their needs. The practice was also able to show evidence that many appointments were available each day and some had gone unfilled, indicating that appointment slots were not oversubscribed. We saw that on the day of inspection there were on the day appointments and pre-bookable appointments were available in the coming days. • There was process for reception staff to identify patients who required an appointment as a priority on the day. This included children and vulnerable patients. • The practice had extended hours appointments in the evening and on Saturdays. • The practice had employed additional staff, many in specialised roles. This increased the number of appointments available and had improved the patient feedback in relation to appointments availability. 	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 01/04/2023)	43.0%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 01/04/2023)	54.9%	59.6%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 01/04/2023)	53.2%	57.1%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 01/04/2023)	74.9%	74.5%	72.0%	No statistical variation

Any additional evidence or comments

- The practice had introduced a new telephone system which provided more capacity and better access to services. The practice were able to demonstrate through audit and data that this had improved the access to the practice by phone, work was continuing and there analysis showed this was improving month on month.
- The practice had recruited a range of additional special such as mental health practitioners, paediatric and palliative care nurses to support the needs of patients and increase the options available to patients seeking support for their health and welfare.
- Patients had options for accessing the practice through an electronic and online system.
- Extended hours appointments were available through arrangements with the PCN and neighbouring practices.
- A range of alternative sources of support were available such as mental health practitioners, social prescribing practitioners and first contact physiotherapists in addition to the GP and practice nurse appointments.

Source	Feedback
NHS.uk website (formerly NHS Choices)	The practice had received 9 feedback reviews in 2023 until the date of inspection. This painted a mixed picture; they received 5 five-star reviews and 4 one-star reviews. The practice had responded to each review posted.
NHS Patient Survey	The practice results have improved substantially. Compared to last year the patient survey results had gone from below England and local averages, to very similar to local and national averages.

CQC Give feedback on care.	CQC received 600 pieces of feedback, 416 (69%) were positive, 162 (27%) were negative and 22 (4%) were mixed both positive and negative. The themes from the feedback relating to the responsive key question were issues about difficulty accessing the practice by phone and the availability of appointments. It was articulated by the practice that these sentiments were based on historic difficulties and that patient opinion was changing as patients found it easier to access the services. This was in keeping with the improvements in patient satisfaction evidenced in other surveys.
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Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	45 (14/06/22-11/07/2023)
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	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
Feedback on friends and family test survey indicated that messages were unclear, and a patient attended the wrong branch location.	Results of friends and family test were analysed and as a result of this piece of feedback the practice amended their test messaging service to ensure the location was clearer.
Complaint that an infection was not detected despite multiple visits to practice.	Process changed if patient returns with same complaint where no improvement ensure swab is taken.
Feedback that queues at reception and not advised of delay in clinic times.	The practice had invested in new electronic check in, which would also advise patients of any clinic delays. This was due to be installed in post inspection.

Well-led

Rating: Good

At this inspection, we found that those areas previously regarded as requiring improvement had all been addressed. The practice is therefore now rated as good for providing well led services.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• At the previous inspection we found the practice leadership didn't have actions in place to respond to the risks and challenges around quality and improvement. At this inspection we found significant improvement in all the areas highlighted in the previous inspection. There were systems in place to ensure that risk was monitored and captured with measures put in place to ensure action was taken. There were quality and performance methods in place to provide assurance of effective processes and procedures. This was indicative of an effective and capable management and leadership process.• Consideration had been given to challenges in primary care and healthcare generally. The practice had responded by adopting different models of working and they had recruited staff from different backgrounds and specialisms to enhance service provision. For example, Child and Adolescent Mental Health Service (CAMHS) practitioners, a diabetes specialist nurse and a palliative care specialist nurse.• The practice developed staff through training and investment in order to improve their job satisfaction and help retain them for a longer term. The practice had developmental assistant practice manager roles, this supported staff to become capable and experienced in practice management and was part of the practice succession planning initiatives.	

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.	Partial
Explanation of any answers and additional evidence:	

- At the previous inspection staff appeared not to be aware of the vision and values for the practice. At this inspection we saw that a practice vision, values and strategy had been reinforced and formalised. This was created in partnership with staff and patient groups.
- Staff understood the vision, values and general strategy of the practice and understood their own role in achieving the practice aims.
- The practice had general aims and ambitions for the practice and had a business plan document in place. However, this was more like a narrative of what had been done and achieved over the year and lacked a formalised or strategic view of the ambitions for the practice in the coming years. There was therefore an inability to track progress towards those aims. The managers stated this was because the practice had approached the end of the five-year business plan and was due to establish a new plan for the coming years.
- Practice values were on display in the public waiting and reception area.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • At the previous inspection we found that staff were generally not aware of the freedom to speak up guardian role or who this was. At this inspection we found that staff understood the role and knew who their guardian was. • Feedback showed that staff were aware of how to speak up or raise concerns when they felt that something was wrong. They stated they knew how and felt confident to do this, they also felt assured that action would be taken as a result. • Feedback on culture was mainly positive. Staff described a positive culture where they felt supported and there were opportunities to develop. Staff stated they enjoyed working at ISSA. One staff member felt unsupported. 	

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

Source	Feedback
CQC staff questionnaire feedback forms.	25 staff members provided feedback on their experiences of working at ISSA. 24 responses were positive and described a positive supportive environment, good

	variety of staff with development opportunities and pride in providing good patient care. There was 1 respondent who stated they did not feel supported.
Interviews with staff on site.	Positive feedback about working at the practice, the teamwork and supportive, approachable managers.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection we identified a reactive and ad-hoc response to quality assurance and improvement. We also found a lack of documentation and assurance around follow up actions and if they had been completed. At this inspection we found improvement in these areas. We found that the practice was undertaking audits and quality assurance projects, had started documenting these and following up action plans and outcomes appropriately. However, audit streams were not consolidated and outcomes were not always fully described. Since the previous inspection all staff policies and operating procedures had been transferred to the new computer system. This enabled better oversight of reviewing and amendment of policies to ensure the latest policy was available and current. The quality of policies had improved, they now had document control and were more comprehensive. At this inspection there was more clarity around governance and accountability structures. The systems of delegation and responsibility were clearer, and the practice was able to demonstrate their approach to sharing and receiving information and how issues were escalated. There was also evidence of oversight of risk and issues. There was an improved documentation and assurance of clinical oversight. Formalised processes were in place to evidence clinical competency, which were documented, reviewed and auditable. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection there were gaps in documentation and oversight of clinical staff. At this inspection this had improved. The practice had recruited additional nursing staff which enabled the lead nurse to better support nurses and health care assistants with supervision and oversight. Staff now felt supported and that their developmental needs had been addressed. Similarly, those staff in advanced clinical roles such as advanced nurse practitioners, associate physicians and clinical pharmacists now had formalised and documented supervision. Assurance of their clinical competence was documented and retained. Oversight of the sessional and salaried GPs and locums was in place through regular supervision, clinical teaching sessions, group learning sessions and oversight by a senior GP. The practice managers had oversight of risk, through quality and performance measurement and a range of clinical and non-clinical audits. Action was taken in response to the risks identified, for example, analysis of the telephone access traffic and call waiting times highlighted that there was a capacity issue with phone lines. The practice responded by arranging for the installation of additional lines to increase capacity. Similarly, the practice identified that nursing staff were stretched and supplemented the staffing with additional nurses and healthcare professionals to ensure they could achieve their expected workloads and objectives. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Managers analysed data from the telephone system to inform their planning of activity and staffing. They identified bottle necks and busy times and deployed extra staff, further 	

analysing the result. They identified that telephone line capacity was an issue and responded by installing more lines.	
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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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Information governance was a compulsory mandatory training module for all staff. Computer systems were password protected had relevant security systems and screens were locked when not in use. Consultations with patients on the telephone were undertaken in consultation rooms with doors closed. Remote access was possible using secure systems for staff who were required to work away from the practice. 	

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

Explanation of any answers and additional evidence:

- A new PPG had been set up with good numbers of interested participants. Two meetings had been undertaken and these had been described as positive and productive meetings. The practice had ideas how they might further develop the PPG to advise and support them going forward.
- The practice engaged in surveys and feedback to understand the experiences of patients.
- The practice manager engaged with other practice managers in the local area to share experience and best practice.
- Staff from the practice attended local PCN meetings to share knowledge and experience. A manager from ISSA was the PCN lead, and the practice were involved and instrumental in PCN initiatives.

Feedback from Patient Participation Group.

Feedback

- PPG members were pleased about the establishment of the group and were committed to working in partnership with the practice to bring about improvements. Feedback provided was mixed, some members were very satisfied with the practice and believed they were providing an excellent service. Some felt there was some improvement needed to make more appointments available, especially for patients who could not call and wait on the call at certain busy times of the day.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • At the previous inspection we found limited evidence of systems and processes to support learning, continuous improvement and innovation. At this inspection we found that these systems were now in place and functioning well. This had led to a significant improvement in many aspects of the service delivery including clinical and non-clinical outcomes. • The newly adopted clinical audits had led to positive outcomes as evidenced by our clinical searches of patient records. We gained assurance that the practice were following the latest best practice guidance and current recommendations. • Furthermore, the practice was able to evidence effective monitoring of their performance over time in order to establish if there were areas to improve upon and demonstrate that improvement was being achieved and sustained. • The practice was a teaching practice and adopted practices to develop staff. Staff delivered extended roles, and this helped to support clinical and administrative functions of the practice. Formal systems of assurance around performance and outcomes were now in place. • There were standing agenda items for incidents and complaints for clinical meetings. There was evidence these fed into processes for making improvements. This demonstrated improvement from the previous inspection. 	

Examples of continuous learning and improvement

- The practice implemented a series of searches around high-risk medicines, MHRA alerts and long-term condition management. This led to a significant improvement in compliance with recommendations and best practice as evidence by our clinical searches of patient records.
- The practice analysed and responded to the results of the previous NHS patient survey and implemented measures to address some of the feedback. For example, they increased the number of appointments available and installed a new telephone system. This led to much better survey results in the latest survey.
- The practice received feedback regarding queues waiting to book in for appointments and had commissioned a new self-check in electronic system to reduce the delay in checking in.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

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

Glossary of terms used in the data.

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