

# Care Quality Commission

## Inspection Evidence Table

### Millstream Medical Centre (1-6581776659)

Inspection date: 07 December 2022

Date of data download: 07 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• There was a safeguarding system and policy in place for vulnerable adults and children which was reviewed in January 2022 to ensure information was correct and kept up to date. There were designated safeguarding leads who held oversight of new and existing safeguarding concerns. Local arrangements and key contacts for making a safeguarding referral were available to staff.</li><li>• Senior managers discussed safeguarding at regular monthly clinical governance meetings. Nurse led meetings were held to discuss vulnerable patients as a standing agenda item. Relevant information was recorded in patient records we sampled. Daily multi-disciplinary team meetings held by clinicians discussed on the day safeguarding concerns where needed.</li><li>• The practice worked across the local Primary Care Network (PCN) and shared safeguarding processes and procedures, which gave guidance for staff to assist those patients who may be vulnerable.</li></ul>	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> <li>All staff had received safeguarding training assessed by the practice as being appropriate to their role and this was refreshed when required, in line with practice policy.</li> <li>Enhanced Disclosure and Barring Checks (DBS), to check the criminal record for someone applying for a job role, were carried out on all clinical staff. For those staff who were not clinical, the practice had carried out a risk assessment to demonstrate why an Enhanced or Standard DBS check had not been undertaken.</li> <li>Clinical staff members had chaperone responsibilities as part of their role.</li> <li>The practice had a system to identify vulnerable patients on record and there were regular discussions between the practice and other community care professionals such as health visitors and social workers when needed.</li> <li>The practice's clinical records system had a safeguarding alert flag for every new consultation record as a reminder for clinicians to record safeguarding concerns or relevant patient information.</li> </ul>	

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: <ul style="list-style-type: none"> <li>There was a recruitment policy in place, which had been reviewed in April 2022 to ensure the most up to date legislation and recruitment guidance was adhered to. The practice had maintained records in relation to immunisations staff had received.</li> <li>The practice had a dedicated induction programme, in addition to a starter pack for locum and temporary staff.</li> <li>We carried out recruitment checks in relation to four members of staff which contained all the required information as per practice policy.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y
There was a fire procedure. Date of fire risk assessment: December 2022	Y
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Health and safety risk assessments had been carried out in March 2022. This included lone working; premises and security; COVID-19; pharmacy and dispensing; patient consultation; workplace stress; working with liquid nitrogen; manual handling and evacuation chair usage. Risks to service users were identified and mitigated appropriately.</li> <li>There was a dedicated fire policy last reviewed in November 2022, which outlined evacuation procedures and the named fire wardens. We identified that the fire warden training had not been reviewed within practice policy timeframes.</li> </ul>	

- The fire risk assessment carried out had not identified any areas for improvement. Emergency lighting testing was completed in November 2022. The fire extinguishers were serviced in July 2022.
- The practice conducted fire alarm tests weekly, records were maintained for both sites. We identified that the practice had not completed evacuation drills in line with practice fire policy timeframes. The practice shared the premises with other healthcare providers. We saw evidence after the inspection of an action plan to implement shared fire evacuation drills on a routine basis.
- Portable appliance testing had been completed in June 2022, whilst equipment calibration had been completed in December 2021. There were no issues identified as actions that required improvement.
- Legionnaire checks of the water system had taken place in September 2022. Records of monthly water checks and flushing records were completed by staff to ensure the water system was safe. Oversight was provided by the infection prevention and control (IPC) lead with the practice manager. The assessment deemed the premises required improvements related to updated servicing of the boiler and water taps that had not been completed at time of inspection. We were provided with evidence after the inspection that showed that these actions had been completed.

## 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:	
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The infection prevention and control (IPC) policy was last reviewed in October 2022. Standard operating procedures were in place and had been reviewed by the practice's IPC lead. This included guidance for staff relating to cleaning arrangements; training and induction requirements; risk assessment and audits; clinical waste; clinical procedures and injuries and incidents. The IPC lead was able to demonstrate compliance with national guidelines.</li> <li>• Appropriate arrangements were in place to manage and dispose of clinical waste. We saw that clinical waste was stored securely prior to being disposed of. Certificates of clinical waste disposals were kept by the practice to demonstrate this.</li> <li>• Appropriate measures were in place to ensure the premises was clean and that sufficient levels of personal protective equipment (PPE) were available where required.</li> <li>• Staff were up to date with IPC training. There was an IPC induction checklist for new staff.</li> <li>• The practice had completed an annual IPC audit in November 2022. This resulted in a practice compliance score of 77%. At the time of inspection, actions were on-going to address shortfalls in this area, including the plan to install splash back panels for rooms with sinks; increased IPC hand hygiene spot check audits; correct storage for equipment and cleaning products. Compliance to the action plan was to be assessed at deadlines set by the practice and re-checked at the next IPC audit in November 2023.</li> </ul>	

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had four salaried GPs who provided cover across the two locations. The provider had recently recruited an additional GP and a practice nurse to assist with providing patient appointments and long-term condition clinics.</li> <li>• The practice was also supported by staff in roles such as the home visiting team, comprised of a paramedic and advanced nurse practitioner.</li> <li>• The practice was able to access additional staff who worked across the primary care network (PCN), for example, two mental health support workers.</li> <li>• There was evidence of staff completing additional training for responding to medical emergencies, for example, sepsis management.</li> <li>• Staff rotas were completed four weeks ahead of time, with oversight of staffing cover where required.</li> <li>• We reviewed the clinician arrangements at the practice's branch site. There were adequate clinical staffing arrangements to ensure in the event of emergency there was no lone working.</li> </ul>	

**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.	Partial
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:

- During this inspection, we conducted a review of patient records within the practice's clinical record system and identified records were managed to ensure patients received safe care and treatment. Records contained relevant, accurate and up to date information in line with current guidance.
- There was a dedicated administration team of staff who were responsible for ensuring urgent and routine patient referrals were actioned and followed up. For urgent referrals, there was a system for staff to check patients had attended their appointment.
- Whilst there was a system in place for processing new patient information and summarising notes, we found that there was a 12 month backlog of summarising patient records. The practice had raised awareness with staff and placed this on the risk register. The practice had recently recruited an additional administrative staff member to help complete the backlog and train other staff in this area. Further training for this staff member in relation to managing patient information and summarising had been booked for January 2023.
- There was a clear documented approach to the management of test results. Staff we spoke with were aware of their roles in relation to test results and tasks were set for clinicians to review these on the same day. The practice had a 'buddy' system to cover clinician absences for outstanding patient results.

## 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)	0.73	0.75	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)	10.6%	9.7%	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)	5.25	4.82	5.28	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	109.9‰	122.4‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small>	0.80	0.61	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>	6.4‰	5.8‰	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.	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

Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p data-bbox="57 405 1540 450">Explanation of any answers and additional evidence, including from clinical searches.</p> <ul data-bbox="105 495 1540 1471" style="list-style-type: none"> <li data-bbox="105 495 1540 719">• Clinical supervision was managed by the practice's lead GP. This provided oversight of performance of non-medical staff prescribing and was within scope of practice to ensure safe care and treatment. Formal records were completed and discussed in conjunction with clinical meetings to provide shared learning of case summaries and best practice guidelines. The practice held daily clinical supervision sessions for all non-medical prescribers, clinicians and GPs as part of a multi-disciplinary approach, to share and discuss clinical cases and best practice.</li> <li data-bbox="105 719 1540 943">• During this inspection, we undertook remote searches of the practice's clinical records system. From our search findings, we determined that patients who had been prescribed high-risk medicines had been appropriately monitored and reviewed, in line with National Institute for Health and Care Excellence (NICE) guidelines. For example, we identified 35 patients prescribed methotrexate, a medicine for inflammatory conditions. We reviewed a sample of five clinical records that showed all patients had received the appropriate monitoring.</li> <li data-bbox="105 943 1540 1055">• There was a process for the safe handling of requests for repeat medicines and evidence of structured medicine reviews for these patients. Policies were in place for medicine management, such as those which set out the monitoring required for high-risk medicines.</li> <li data-bbox="105 1055 1540 1167">• We reviewed a randomised sample of five medicine reviews and found that the practice had recorded the appropriate detail. Patients had treatment plans in place with regular monitoring to ensure safe care and treatment.</li> <li data-bbox="105 1167 1540 1256">• The practice had a process to manage information changes to a patient's medicine including changes made by other services, for example, the out of hours provider (OOH).</li> <li data-bbox="105 1256 1540 1471">• Emergency medicines were stored appropriately and were accessible to staff. Staff undertook stock checks, including a review of expiry dates. Medicines had been risk assessed to ensure appropriate medicines were included. Medical equipment included a defibrillator as well as oxygen cylinders, with a service agreement for replacements when oxygen levels were low or expired.</li> </ul>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y

Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> <li>• The dispensary service had effective leadership from the Pharmacist partner and a lead GP. The dispensary lead supported staff in their designated roles. Staff competencies were reviewed and appraisals conducted annually.</li> <li>• There was a comprehensive standard operating procedures, which covered all aspects of the dispensing process and there was a system in place to monitor staff compliance. Dispenser audits were carried out for quality assurance.</li> <li>• There was a process for Controlled Drugs (CD) disposal. We saw evidence of an the audited CD log. Controlled Drugs were stored in a locked cupboard, the keys were kept securely in a designated place. There was a set procedure for the dispensary issue of Controlled Drugs to patients.</li> <li>• We saw evidence of a significant events overview, specific to the dispensary, which discussed the actions taken and shared learning. Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts specific to the dispensary included authorised verification reviews completed by the dispensary lead.</li> <li>• The dispensary took part in the Dispensing Services Quality Scheme (DSQS) annual audit which focused on the provision and monitoring of high-risk medicines dispensed to patients. In particular, to ensure patients were provided with guidance alert cards at the point of dispensing and recorded in patient notes. The dispensary showed evidence of regular patient searches completed and compliance to the issue of alert cards for patients prescribed these medicines. There was an action plan in place to complete a re-audit, training for staff and a set agenda item to the dispensing team meetings.</li> </ul>	

### 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:	16
Number of events that required action:	14
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Staff were clear on their roles to raise safety incidents and how to report concerns appropriately.</li> <li>• The practice was able to evidence learning and the dissemination of information relating to significant events. Following a significant event, the practice advised that learning from the event was investigated and discussed at multi-disciplinary team meetings. Formal minutes were recorded and shared to staff via email correspondence.</li> </ul>	

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

Event	Specific action taken
An incident occurred where a patient was administered the wrong vaccination based on incorrect patient records.	The incident was investigated to find the root cause. The patient was contacted and an apology was provided in line with the duty of candour. The provider had increased immunisation appointment duration times to ensure clinicians had the appropriate information needed. For example, guidance on vaccination schedules from the Green Book. Learning had been shared with staff through a significant event meeting to minimise the risk of reoccurrence.
An administration incident occurred where upon updating a patient record, an appointment was made for an incorrect patient.	The incident was reviewed openly and transparently. The patients were contacted and an apology was provided in line with the duty of candour. The practice had reviewed the administration task procedures and made changes to ensure patient verification checks were completed before tasks were completed. Learning had been shared with staff through a significant event meeting to minimise the risk of reoccurrence.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• We saw examples of actions taken on recent safety alerts, for example, regarding the use of Hydrochlorothiazide, a medicine used to treat high-blood pressure or edemas. This alert was raised due to an increased risk of skin cancer. We identified two patients prescribed this medicine. We saw updates to patient records to indicate this alert had been identified and discussed with the patients.</li> </ul>	

- The provider was able to demonstrate that all relevant safety alerts had been responded to appropriately and that routine patient searches had taken place to ensure safe care and treatment.

## 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.	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 prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• The practice had a multi-disciplinary team approach to clinical supervision. Oversight was provided by the practice partners, cascading relevant information through daily clinical meetings to ensure staff were kept up to date with evidence-based guidelines.</li><li>• GPs referred patients to secondary care and used two-week wait (2ww) pathways where appropriate. A two week wait pathway is where the cause of a patients presenting condition may be in relation to cancer. We saw the practice had kept up to date with processing two-week wait referrals to ensure patients were seen in a timely way. Safety netting was in place to confirm patients had an appointment upon lack of receipt of referral.</li><li>• All 2ww referral responses were sent to the referring clinician for learning from patient outcomes and ensure cancer referral pathways were correctly followed based on patient symptoms. Clinicians had designated follow-up appointment slots to allow for continuity of care, where cancer reviews had taken place.</li></ul>	

- The practice had a process in place to ensure patients with a cancer diagnosis were informed of the support available and cancer care reviews were completed as per national guideline timeframes. The practice monitored compliance to patient pathways through on-going routine reporting and learning events held bi-annually.
- Patients were given advice on what to do if their condition deteriorated, for example, call back or contact with the out of hours service. Respective communications between the out of hours service was highlighted when we spoke with senior staff, including the transfer of discharge notifications and changes to patient medication.
- The practice had a 'same day care pathway' which offered clinically vulnerable patients or patients requiring urgent care, triage appointments to ensure patients were receiving accessible and effective care.

## 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.
- The provider had a system to ensure eligible patients were able to access health checks at the practice. This was also offered and carried out by the home visiting team for those patients that were housebound.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74 and newly registered patients. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The provider worked with the primary care network (PCN) and shared protocol in relation to the learning disabilities patient pathway. All patients with a learning disability were offered an annual health check. This was split into two parts with face to face appointments with a practice nurse or health care assistant which covered and an initial physical screening, including monitoring of any long term conditions. The second part held face to face appointments with the lead GP and learning disabilities consultant to review clinical needs, including medicines and treatment care planning. There were systems in place to follow-up patient outcomes and further communicate with patients who were identified as non-respondants. Reasonable adjustments were offered to patients to ensure extra time was available in appointments and quiet areas if needed.
- The practice worked with the local commissioning team to raise awareness and shared learning from reviews of lives and deaths from people with a learning disability and autistic people (LeDeR).
- 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 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.
- During this inspection, we undertook remote searches of the practice's clinical records system. From our search findings, we determined that patients who had been prescribed gabapentinoids,

medicines used to treat epilepsy, had their ongoing needs assessed and monitored. We identified 111 patients prescribed these medicines. We reviewed a sample of five clinical records in detail that showed patients had received the appropriate monitoring.

## Management of people with long term conditions

### Findings

- We conducted remote searches on the practice’s clinical records system and found that patients who required monitoring of long-term conditions were followed-up appropriately in line with current national guidelines. Accurate records were kept and coded effectively. Patients with long-term conditions were offered a review of medicines and/or blood monitoring to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. The practice had employed a diabetes specialist nurse and long-term conditions nurse to assist with managing patients and provided clinics in this area.
- 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.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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)	113	121	93.4%	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) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	104	118	88.1%	Below 90% minimum

The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	104	118	88.1%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	105	118	89.0%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	132	149	88.6%	Below 90% minimum

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

### Any additional evidence or comments

- Clinical staff we spoke with were aware of the practice's processes to provide further education to assist young families in the importance of these immunisations.
- The practice monitored Did Not Attend (DNA) appointments with appropriate follow-up processes to ensure children were safeguarded from potential abuse or neglect.
- There were systems and processes in place to request vaccination records for children who were registering with the practice.
- Patients could book immunisation appointments online for extended hours. The practice had plans in place to introduce online appointment access for immunisation appointments during normal hours.

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)	72.3%	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)	66.2%	67.4%	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)	65.9%	69.9%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two	58.0%	62.3%	55.4%	No statistical variation

week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)				
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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 did not meet the minimum 80% target of eligible patient uptake of cervical screening. The practice combined female health appointments with other acute or routine patient needs where possible. At the time of inspection, female health appointments were available to book in advance. The practice had arrangements in place with the other providers in the area to offer extended access appointments to improve the uptake of cervical screening.

### 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

### Any additional evidence or comments

- The practice had a comprehensive quality improvement audit program which was reviewed throughout the year by the clinical team, with findings discussed at clinical meetings. For example:

The practice had conducted an audit in April 2022 reviewing hormone replacement therapy (HRT) prescribing to ensure female patients were not prescribed HRT without a progesterone, a medicine that regulates the menstrual cycle, except for those who have had a hysterectomy or those who have a coil fitted.

- 296 patients were identified as having an HRT preparation issued within the previous six months.
- Four patients were identified as needing prescriptions for progesterone. All four of those patients had expired Mirena coils.
- Two had already been booked in for replacements.
- The practice had contacted the remaining two patients to ensure effective care and treatment was provided.
- The practice discussed findings with the clinical team and updated routine audit searches and recall processes to ensure that Mirena coils do not expire in patients prescribed HRT.
- The practice had an action plan to complete a second cycle audit to review the effectiveness of the implemented processes in April 2023.

The practice had conducted an audit in July 2022 to monitor the frequency of patients who had ring pessaries fitted were reviewed and replaced appropriately. Ring pessaries are non-surgical treatments for female patients with pelvic organ prolapse. National Institute for Care Excellence (NICE) guidance states ring pessaries should be reviewed and replaced every six months.

- 14 patients were identified as having had a ring pessary fitted in the previous two years.
- Of these patients, six (43%) had their pessaries changed within four to six months.
- Three patients (21%) with pessaries were changed early (either due to issues with the pessary or individual reasons documented).
- Five patients (36%) with pessaries were changed outside of the recommended timeframes.
- Nine patients (64%) who had pessaries changed, had records to confirm they had the appropriate review within recommended timeframes. All of these patients had been informed of the recommended guidelines and risks of the treatment at the time of appointment.
- The practice had discussed findings with the clinical team and updated patient recall and task management processes. Clinicians were informed on the requirements to ensure patients had received all of the required monitoring information at the time of appointment.
- The practice had an action plan to complete a second cycle audit to review the effectiveness of the implemented processes in July 2023.

## 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Staff mandatory training deemed by the practice training policy was completed and up to date. There was a system in place to ensure records were checked regularly.</li> <li>• Staff told us they were given protected time to complete training.</li> <li>• We observed records which verified appraisals were conducted with staff, staff performance was monitored and objectives were set. Staff were supported to meet the requirements of professional</li> </ul>	



revalidation, including registrations with the General Medical Council (GMC) and Nurse Midwifery Council (NMC), where appropriate.

- There was a recruitment policy which outlined the process for new starters, including locum and temporary. Induction checklists were in place for new staff members for probationary review.
- The practice had used an external proficiency auditor to review a randomised sample of clinician consultation records as part of performance competency and quality development for staff.

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had a system to manage communication between services about patients so that they received consistent and co-ordinated care. For example, meetings took place between the local Out of Hours service and the provider for the safe handover of clinical records and treatment plans of patients moving between the services. The practice used a task management system which clinicians used to raise specific clinical tasks with the lead GP outside of the set daily meeting as a safety mechanism.</li> </ul>	

## 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:	

### Any additional evidence or comments

- The practice had arrangements to provide intermediate care services at two local nursing homes. Intermediate care services are where patients do not require hospital care but 24 hour support is available, that cannot be provided at home. The practice provided weekly ward rounds, completed

by the GP partner and home visiting team, comprising of a visiting paramedic and advanced nurse practitioner.

- Daily home visit appointments were available to those patients that were vulnerable and high risk, as well as health checks and routine care, such as for patients with long-term conditions.
- Same day appointments and longer appointments, as part of reasonable adjustments, were offered when required.

## 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"> <li>• During a review of clinical records, we identified that consent and decision making was recorded in line with legislation and guidance.</li> <li>• Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were in place for patients when needed. We reviewed four of these directives and found they had been completed with patient involvement and reviews had been done in line with guidance. Recommended Summary Plan for Emergency Care and Treatment (RESPECT) forms, to record patient's wishes on treatment received and whether they wanted to be admitted to hospital, were used for end of life patients where appropriate.</li> </ul>	

# 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"> <li>We reviewed the most recent information available for the practice regarding patient satisfaction. This included information from the national patient survey up to April 2022 and recent enquiry trends. We also looked at information on NHS.uk website and information from Healthwatch which highlighted that patients were treated with kindness and respect.</li> </ul>	

Patient feedback	
Source	Feedback
<ul style="list-style-type: none"> <li>Observations made during the inspection</li> </ul>	<ul style="list-style-type: none"> <li>We carried out observations in the reception area where patients attended in person, as well as the administrative area where staff took telephone calls. Staff were helpful and courteous toward patients and were compassionate in their approach.</li> </ul>
<ul style="list-style-type: none"> <li>NHS.uk website (formerly NHS Choices)</li> </ul>	<ul style="list-style-type: none"> <li>At the time of the inspection, there had been three ratings and reviews for the period of December 2021 to December 2022. Of the three reviews, one was a three-star review, two were five-star reviews. Patients' comments reflected positive for access to appointments and how caring staff were.</li> <li>The practice had not responded to reviews during this period. The practice had previously taken themes from this feedback as part of complaints management review.</li> </ul>
<ul style="list-style-type: none"> <li>Internal patient compliments</li> </ul>	<ul style="list-style-type: none"> <li>From December 2021 and December 2022, the practice received 29 patient feedback surveys. Themes reflected telephone access and the appointment system was positive. The practice had responded to feedback with an individual response and an invitation to discuss the feedback further. The practice implemented a 'you said, we did' feedback response system to showcase improvements to the service.</li> </ul>
<ul style="list-style-type: none"> <li>'Friends and Family Test' (FFT) patient feedback</li> </ul>	<ul style="list-style-type: none"> <li>From May 2022, the practice had received 1909 responses to the 'Friends and Family Test' (FFT) feedback survey. This showed a 21% response rate from a total of 8968 appointments. A total of 94% recommended the practice, with 1506 'very good' and 285 'good' responses.</li> </ul>

## 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)	91.8%	88.1%	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)	90.9%	87.9%	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)	95.4%	95.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	82.5%	79.0%	72.4%	No statistical variation

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had a designated community services area within the reception.</li> <li>The practice had worked with the Primary Care Network (PCN) and had access to a mental health team, comprised of two mental health support workers and a social prescriber to ensure patients had access to community and advocacy services.</li> </ul>	

Source	Feedback
Interviews with patients.	The two patients we spoke to during our inspection told us staff gave them adequate time and information so they could be actively involved in their care and treatment.

### 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)	89.2%	93.0%	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Interpretation services were available as well as leaflets in other languages and in easy read formats, including braille.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> <li>The practice had identified 121 of the patients on their list as being carers. This was approximately 1.2% of patients.</li> </ul>
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>The practice had been awarded a silver award for caring for carers by a local charity working in partnership with the local authority. They had won this award for their work with carers because they had met a range of criteria such as ensuring priority and flexible access to appointments.</li> <li>The practice had a dedicated carers lead which provided patient referrals to Carer Support Wiltshire.</li> <li>New patients registered as carers were sent a letter with supporting information and resources available at the practice.</li> <li>Carers were invited to 'coffee morning' sessions which included health check provisions.</li> </ul>

How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>Staff told us that if families had experienced a bereavement, the practice contacted them and a face to face appointment was offered. Further advice was also offered and families were signposted to relevant support groups, such as the practice mental health support workers.</li> </ul>
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## 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"> <li>Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.</li> </ul>	

# 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice held a patient engagement event in June 2021 to obtain a greater understanding to patient needs, including themes in relation to patient access.</li> <li>• The practice had completed a patient needs analysis and identified that the triage appointment model (where patients with urgent or routine requests book onto a same day list) from 2019-2021 and had identified a significant reduction in diagnosis of conditions and treatment intervention time than the previous patient appointment model (where patients booked a dedicated appointment slot ahead of time).</li> <li>• Between January 2022 and December 2022, patients had given feedback to the practice reporting positive trends for telephone and appointment access. For example, the practice had responded to the needs of the patient population through emphasising continuity of care where possible. Patient appointment requests for specific clinicians were considered and allocated, particularly for on-going care and treatment. Rotas had been adapted to include follow up slots for GP's and Advanced Nurse Practitioners (ANP's) to ensure continuity of care.</li> <li>• Patients could book further appointments with the clinician during their appointment where appropriate, including additional diagnostic tests to improve patient access and prevent re-triage.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:00am – 8:00pm
Tuesday	8:00am – 6:30pm
Wednesday	8:00am – 6:30pm
Thursday	8:00am – 8:00pm
Friday	8:00am – 6:30pm
Appointments available:	Routine face to face appointments with a GP were available from 08:30am to 6:30pm. Appointment triage telephone calls were available from 8am to 6:30pm.

The practice worked with the primary care network (PCN) to provide additional access to pre-booked appointments on weekday evenings up to 8pm and extended access through Salisbury Walk-in Centre on Saturdays.

### 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 was military veteran accredited to enhance the support and access for military veterans.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 8pm on a Monday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travelers and those with a learning disability. People in vulnerable circumstances were easily able to register with the practice.
- 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



Explanation of any answers and additional evidence:

- Routine clinic availability was offered to patients to book six weeks in advance of time, including GP appointments, nurse led appointments and long-term condition clinics.
- The practice had used a triage system, to allocate appointments according to clinical need. Online access to the appointment triage was available.
- Patients seen through Out of Hours services and 111 had their records sent to the practice through task management processes and letters. The practice reserved dedicated appointment slots for patients from the Out of Hours service to book into. A dedicated phone line was available for urgent cases to be communicated efficiently.
- The practice planned clinician rotas to ensure patients seen through triage were given timely care and treatment, including planning for unexpected circumstances. For example, the practice were able to adapt to the rise in public health Strep A infection rates by ensuring there were enough advance nurse practitioner (ANP) staff to undertake higher demands of triage telephone calls and face to face appointments to patients who urgently need it.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England 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)	81.8%	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)	77.1%	62.7%	56.2%	Tending towards variation (positive)
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)	81.7%	60.5%	55.2%	Variation (positive)
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)	83.8%	76.6%	71.9%	No statistical variation

### 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.	54
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had a dedicated complaints handler who provided oversight for investigating and responding to complaints received across both sites. The practice had a complaints policy in place which included information for response timeframes.</li> <li>At the time of inspection, we identified that from the 54 complaints the practice received in the last 12 months, there were two open complaints. We reviewed both open complaints and found that the patients were communicated to in a timely way, with extension acknowledgement letters sent for ongoing investigations, in line with the practice's complaints policy.</li> <li>The practice had an open and transparent approach to complaints. Investigations were conducted by relevant staff. Outcomes from investigations were shared at team meetings and with individual staff as needed. For example, when a patient complained about difficulties in ordering repeat prescriptions, the practice reviewed their website and made changes to the guidance for easy access. This update was shared in a monthly staff newsletter.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
There was an issue with the clarity of verbal treatment discussed by a clinician to a patient.	<ul style="list-style-type: none"> <li>In October 2022, the practice had investigated the patient medical record and found there was a correct diagnosis and treatment plan in place, resulting in no changes required to the patient record. The practice had reviewed consultation processes during clinical supervision sessions to ensure guidance was available for staff and reduce the risk of reoccurrence. The complaint was responded to appropriately in line with practice policy.</li> </ul>
Aggressive behaviour was shown by a patient.	<ul style="list-style-type: none"> <li>The practice had updated the zero-tolerance policy to include guidance on warnings and escalation processes. Signage was implemented in the practice waiting areas.</li> </ul>

## Well-led

Rating: Good

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels to deliver high quality sustainable care.**

	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"><li>• The practice had used NHS England (NHSE) and local medical committee (LMC) recommendations to identify learning and implement service improvements from legacy patient safety concerns reviewed in June 2020. The practice continued to work with and receive support from the local commissioners to ensure patients received safe and effective care and treatment. For example, the practice reviewed and updated standard operating procedures including the introduction of daily clinical supervision and comprehensive reviews for clinicians to assess competency.</li><li>• The partners met weekly to monitor actions against their business strategy plan. There was an assessment tool which identified objectives and areas where additional support and resources was required to improve and sustain services. Risks were reviewed and actions updated on the provider risk register accordingly.</li><li>• Strengths, weaknesses, opportunities and threats (SWOT) analysis had been conducted in April 2021, which identified key areas for improvement to service quality with an action plan in place to address any shortfalls in performance.</li><li>• The practice had a succession plan in place to replace those who were likely to retire and planned to support staff to encourage leadership in key areas in the practice.</li></ul>	

### 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
Explanation of any answers and additional evidence:	

- There was a mission statement displayed on the practice's website which staff were aware of. Staff said they were proud to work for the practice and there was support available to carry out their roles.
- The practice had a set of values developed in collaboration with staff underpinning the overall mission statement.
- There was a business strategy and improvement plan in place. This included plans for future developments and logistics to the service locations, including the branch surgeries and reintroduction of community services post COVID-19 pandemic.

## 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"> <li>• The incident reporting system complied with the requirements of the duty of candour.</li> <li>• Staff were able to speak up openly if they had any concerns and the working environment was friendly and supportive. Staff had access to a freedom to speak up guardian and a mental health first aider.</li> <li>• The practice had a whistleblowing procedure available for staff to access electronically and in paper format at the practice.</li> </ul>	

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

Source	Feedback
Eleven staff feedback forms	<p>We distributed staff questionnaires to practice staff. Common themes from responses included:</p> <ul style="list-style-type: none"> <li>• Staff worked in a friendly and supportive environment.</li> <li>• Practice management were open, transparent and approachable.</li> <li>• The provider acted on staff feedback. Views and opinions were valued.</li> <li>• Staff considered that patient access was a priority during the COVID-19 pandemic and resuming operations to business as usual.</li> </ul>

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management. However, not all systems had been fully embedded.**

	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.	Partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There were systems in place to ensure patient care pathways and protocols were followed in line with national guidelines.</li> <li>• We conducted clinical records searches and found that there was a consistent approach to managing safety alerts.</li> <li>• There was oversight in the system to manage mandatory training compliance, of which all staff had completed mandatory training modules.</li> <li>• We identified issues at the inspection not recognised and actioned by the practice's own governance systems. For example, although there were policies and procedures for safe working practices in relation to Control of Substances Hazardous to Health (COSHH), the practice had not ensured the external cleaning contractor had maintained safety data sheets for four cleaning products. There was a risk that staff did not have the appropriate guidance in relation to the cleaning products stored at the practice. We saw evidence after the inspection that the practice had added the relevant COSHH data sheets and implemented monthly safety checks with the cleaning contractor.</li> <li>• There was a lack of oversight to ensure that backlogs of activity were managed in a way that kept patients safe and minimised delays to treatment. Staff did not always have the correct updated information required to deliver safe care and treatment. There was a backlog of patient summarising (the process of extracting and coding patient health records) from July 2021.</li> </ul>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• There was a business continuity policy in place that was last reviewed in November 2022. This gave guidance to staff for the preparation of major incidents.</li> <li>• The practice had a system in place to liaise with specialists when managing patients for specific conditions such as dermatology or musculoskeletal conditions, including assurance checks to ensure referrals were processed and followed-up.</li> <li>• The three practice partners and the management team met weekly to review performance and risks. There was a risk register in place and action plans were in place to address shortfalls identified. For example, we saw evidence of the ongoing actions in response to transferring electronic records to an updated system, which was appropriately risk assessed and monitored by the leadership team.</li> </ul>	

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had used data to monitor and improve patient access through the completion of key performance indicator (KPI) telephone call log audits. The practice used call abandonment rates (an abandoned call is an inbound call that does not get answered, a high abandonment rate can indicate safety concerns) and patient waiting times to monitor performance. We saw evidence of four weeks of telephone audit data. For example, a total of 1504 calls and 16 calls abandoned</li> </ul>	

(98.9%) during the last week of October 2022. The average waiting time was two minutes and 10 seconds per call.

- We saw evidence of telephone call audit data from a week in November 2022 that showed a total of 1381 calls, none of which were abandoned. The average waiting time was two minutes and 11 seconds per call. Oversight in this area was managed so that appropriate administrative support was given during busy periods and throughout the day where patient demand was at its highest.
- The practice had not needed to make any statutory notifications to relevant organisations such as the Care Quality Commission (CQC) or National Health Service England (NHSE) within the last 12 months. However, members of the leadership team were aware of their responsibilities to do so if a notification was required.

## 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"> <li>• Patient data and information was stored securely in line with digital security standards with relevant information was made available for patients to access in line with privacy, consent notices and general data protection regulations.</li> </ul>	

## 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.	N
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:	
<ul style="list-style-type: none"> <li>• At the previous inspection, we highlighted that the practice held public engagement sessions alongside the local commissioners to announce the rebranding and change to the provider partnership, which included changes to the leadership team.</li> <li>• The practice had plans to introduce a Patient Participation Group (PPG) in April 2023. The practice worked with the Local Medical Committee (LMC) and NHS England (NHSE) with the ongoing investigations and review of patient safety concerns that were raised relating to the previous provider. Patient feedback and views on treatment and care were obtained in other ways, such as surveys, 'Friends and Family Test feedback' and patient engagement sessions.</li> <li>• Oversight of patient feedback was managed effectively. We saw themes particularly reflected patient access and person-centred care were positive.</li> <li>• The practice involved staff with improving the services for stakeholders. We saw evidence of a staff feedback project completed in October 2022. Departments were given the opportunity to propose changes by level of priority. For example, further training opportunities; new equipment; updated website information and recruitment of additional staff were all suggested. We saw evidence that the practice had responded and implemented changes despite cost implications.</li> </ul>	

## 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"> <li>• The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, there was a clear plan for conducting clinical and non-clinical audits, with dedicated leads for audit areas. Outcomes and learning were shared with staff.</li> <li>• In the past 12 months the practice had carried out a systematic and detailed analysis and review of all its systems and procedures. They had produced plans including new care pathways, goals, targets and month by month actions plans to set out how they wanted the practice to improve its services. These covered services for patients with all the common conditions. We saw numerous examples of these actions plans being followed and completed.</li> </ul>	

## Examples of continuous learning and improvement

- The GP Partner presented a quality improvement project to the Royal College of Psychiatrists in December 2022 for the practice's innovative service to patients with learning disabilities. The practice had taken a two-part approach to delivering care for patients with learning disabilities. Patients were invited to an annual face to face review with a practice nurse to complete screening tests and health questionnaires. Patients were then further invited to a face to face



clinical consultation or home visit with the GP partner and Learning Disabilities Consultant where medicines, treatments and further care for conditions were reviewed.

- The practice has shared the learning disability care pathway model across the Primary Care Network (PCN) in the locality which had been recognised by the local commissioners.
- The impact of completing the comprehensive annual learning disability pathway showed positive results such as improving adherence to national guidance in relation to medicines; identifying early intervention in patients with underlying health conditions; improved response to secondary care referrals; reviewed unclear diagnoses in person; further education and training for practice staff and less medical isolation for vulnerable patients.
- The practice had identified 44 patients (0.4%) on the learning disability register at the time of inspection. All patients were coded as vulnerable adults which ensured further support was available when needed, such as reasonable adjustments and flexibility of care.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

## Glossary of terms used in the data.

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