

Care Quality Commission

Inspection Evidence Table

The Practice Bowling Green Street (1-4761023217)

Inspection date: 23 and 29 June 2022

Date of data download: 20 June 2022

Overall rating: Good

At the previous inspection in December 2020, we rated the practice as requires improvement overall. This was because the practice was rated as requires improvement for providing safe and effective services.

At the inspection on 23 and 29 June 2022, we found that the practice had maintained the improvements noted at the previous inspection. The practice is now rated as good for providing safe and effective services.

Safe

Rating: Good

At our previous inspection on 11 December 2020, we rated the practice requires improvement for providing safe services because:

- Some patients' records were not correctly coded, and this could mean care was not delivered in a safe way
- Not all patient records were updated in the practice system to provide assurance that appropriate monitoring was in place when blood tests were completed at hospital or elsewhere. This made it difficult to ensure patients were monitored for the medications they were being prescribed.

As a consequence of the improvements seen during this inspection on 23 and 29 June 2022, the practice was 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.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had systems and processes in place to ensure that patients were protected from harm. Evidence of safeguarding alerts on adult and children's records were seen during the remote records review. There were also alerts on most of the siblings of all five children reviewed and some of their parents. Good practice would be to include alerts on the records of all family members of children with safeguarding concerns. This would reduce the risk of staff not being aware that there were safeguarding concerns about a family when reviewing a patient which could lead to them not making an adequate assessment or referring for support appropriately. We were shown evidence that this had been actioned during the onsite visit.</p> <p>We saw that regular meetings were held to discuss the child and adult safeguarding registers. The practice worked closely with the health visiting team to share information and discuss patients of concern. The practice also referred patients to the social prescriber for support and advice.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The provider maintained a recruitment and selection policy and we reviewed two staff records and found recruitment checks were carried out in accordance with regulations. The provider used an electronic recruitment system, which enabled applicant tracking to ensure all the required information was obtained.</p> <p>The provider had recently amended their policies to ensure that all staff who had direct patient contact were up to date with their routine immunisations. The provider had completed a gap analysis and had asked staff to provide documented evidence of immunisation status by 17 July 2022. Where immunisation status could not be evidenced, blood tests would be taken and staff offered immunisations as required.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 16/06/2022	Yes
There was a fire procedure. Date of fire risk assessment: 09/2020	Yes
Actions from fire risk assessment were identified and completed.	Yes

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.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 29/03/22 & 17/05/22	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had developed a detailed action following the infection prevention and control (IPC) audit dated 17 May 2022 to address the issues highlighted. The action plan clearly identified which member of staff was responsible and a date for completion. However, we noted that a number of issues highlighted in the March 2022 audit had not been addressed, for example build-up of limescale and use of temporary closure on sharp bins, despite their inclusion in the action plan put in place at that time.</p> <p>A member of the nursing team acted as the IPC link within the practice and was supported by the provider IPC team. Staff received IPC training and relevant updates as required.</p> <p>The building management team was responsible for the water systems management (Legionella). The legionella risk assessment had been completed in June 2021.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider recognised that staffing was an ongoing challenge, both in terms of recruitment and retention. The provider encouraged staff who worked within the organisation the opportunity to work at the practice to experience working with the practice population prior to committing to working there on a permanent basis. The practice benefitted from being part of DHU Healthcare and had access to a staff pool to cover any potential shortfalls in staffing.</p> <p>The provider was actively recruiting for administrative / reception staff to fill vacancies and told us that an advanced clinical practitioner would be joining the team in the near future.</p>	

All staff, including locum staff, received an induction, and an information resource pack was available in all consulting rooms.

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a process for managing two week wait referrals. Patients were advised to contact the practice if they have not had a secondary care review in two weeks. The reception team had a process in place to chase the referral to ensure that the patient was reviewed in secondary care. Referral templates were used and contained appropriate information.</p> <p>There was a process for managing pathology results. The practice aimed to review all results by the end of the working day but acknowledged this could be difficult if there were not enough clinical staff working. Test results in the pathology inbox were reviewed. Twenty-seven results were waiting to be filed from 18th to 23rd June. All the abnormal results from the 20th June had been viewed by a clinician, three abnormal results from 21st June were still waiting to be viewed.</p> <p>Clinical searches the Care Quality Commission (CQC) conducted during the inspection indicated that systems were in place to review and act upon information received by the practice.</p>	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.45	0.69	0.79	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	6.0%	8.8%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	4.48	4.65	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	89.5‰	95.6‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	1.06	0.79	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	4.5‰	6.2‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a drugs requiring routine monitoring policy including high risk medicines management. The practice used scheduled tasks to record monitoring requirements and ensure that monitoring checks were done. Evidence of this was seen during the records review. The pharmacist ran batch reports every few months as a continuous audit to check that high risk drug monitoring checks were up to date. Monitoring was also checked at medication reviews as another failsafe. The CQC searches performed for high risk drugs showed that patients were being monitored appropriately and followed up when they failed to attend for appointments.</p> <p>The practice had medication review procedures in place and the pharmacy team were carrying out structured medication reviews. The pharmacists had reviewed all medications including discussing compliance and side effects as well as checking monitoring was up to date.</p> <p>The records review showed that the practice had taken steps to reduce benzodiazepine and hypnotic (Z-drug) prescribing to reduce the risk of addiction. This included not putting medicines on a patient's repeat list, highlighting the risks and addictive nature of these medicines and supporting the mental health team in helping patients wean off these medicines.</p> <p>The competency of all clinical staff was checked through regular audits of consultations and prescribing.</p>	

Medicines management	Y/N/Partial
<p>The practice had a stock of medicines available in the event of a medical emergency and there was a system in place to monitor stock levels and expiry dates. A risk assessment had been completed for the suggested medicines that the practice chose not to stock.</p> <p>Staff had access to a cold chain and fridge temperature policy. Fridge temperatures were recorded twice daily and were within the required range. The practice also had a data logger which alarmed when the temperature was out of range. The information stored on data logger was downloaded and checked on a weekly basis.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong/did not have a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	25
Number of events that required action:	15
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a process for raising and investigating incidents/significant events. There was an Incident Reporting and Investigation Procedure which was seen during the inspection. This referenced Duty of Candour and that root cause analysis was done during the incident investigation.</p> <p>Staff understood the process and were encouraged to report incidents via DATIX and there was a positive reporting culture.</p> <p>The practice had a log to record significant events/incidents, lessons learned from them and actions taken. Incident reporting had increased in the last 12 months as staff were aware how to use DATIX.</p> <p>Governance meetings with management of the umbrella organisation were used to discuss incidents. Newsletters, email communications and clinical director letters were used to communicate learning from incidents to staff.</p> <p>A recent significant event was discussed as a member of the nursing team had identified that there were delays in ordering stock which could have a potential impact on patient care. A root cause analysis was performed which identified challenges in the capacity of the stock ordering team. The plan was to implement a robust ticketing system and process with emails being sent to the administration team to log equipment and stock requests and allow these to be managed more effectively.</p>	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A patient was prescribed a specific time limited medicine by secondary care and practice staff had added this medicine to the patient record so that it could be requested as repeat prescription.	The medicine was removed from the repeat prescribing list and any future requests were managed by the practice pharmacist. Following this incident it was agreed to develop policies and procedures for the management of hospital only medicines. The practice had developed and implemented policies for shared care medicines, hospital only medicines and medicines identified in discharge letters.
A delay in a patient receiving antibiotics due to the fall back smartcard used by some locum staff not including electronic prescribing permissions.	The practice was not aware that the smartcard did not have electronic prescribing permissions until the patient contacted the practice as the prescription had not been received at the pharmacy. The prescription was immediately generated and sent by a different clinician. The practice has requested that electronic prescribing permissions are added to the smartcard. In the interim period, any prescriptions will be printed off and given to the patient when using the smartcard.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a process for managing safety alerts. It maintained a medicines safety dashboard including safety alerts and used a safety alert log to record actions taken in response to alerts. The records reviewed showed that appropriate action had been taken in response to safety alerts. For example: Women of child bearing age prescribed certain medicines that may cause congenital malformations in babies had been advised about the risk of pregnancy and the use of effective contraception and/or had a pregnancy prevention programme in place to make patients fully aware of the risks and the need to avoid becoming pregnant.</p>	

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.

At our previous inspection on 11 December 2020, we rated the practice as requires improvement for providing effective services because:

- Medicine reviews were not up to date.
- Cancer screening figures were still lower than average for the practice population.
- Care plans were not in place for all patients who required them, and those care plans in place contained minimal detail.

As a consequence of the improvements seen during this inspection on 23 and 29 June 2022, the practice was rated as good for providing effective services.

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence:	

The practice had strengthened the procedures in place around medicine reviews. The practice had medication review procedures in place and the pharmacy team were carrying out structured medication reviews. Searches were in place to identify patients on controlled drugs needing medicine reviews and patients on more than 10 medicines to ensure polypharmacy reviews were taking place. The practice had implemented a new system for medicine reviews in May 2022. This involved doing medicine reviews in the patient's birthday month and providing a "one stop shop" appointment for all monitoring checks.

The practice acknowledged there was a historical backlog of medicine reviews, but was working through this with the pharmacists, who completed 20 to 30 reviews a day. Patients who were on controlled drugs, polypharmacy (multiple medicines) and high risk medicine were being prioritised to have their medication reviews.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had a system for reviewing the immunisation status of new patients, often from overseas, and ensuring they were up to date in accordance with local guidelines. However the minimum 90% target for all five childhood immunisation uptake indicators had not been met.
- Uptake of screening for cervical cancer was below the target of 80% and below the local and national averages for breast cancer and bowel cancer.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice 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.
- Care plans are in place for patients with severe mental illness and learning disabilities, although these had been produced by the Learning Disabilities and Mental Health Teams. Two patients with mental health problems had been reviewed by the mental health facilitator in the last 12 months and had their physical and mental health assessed. However, their care plans had not been updated since early 2021. Good practice would be to provide the patient with an updated care plan from the practice.

Management of people with long term conditions

Findings

- The practice used registers to manage and monitor patients with long-term conditions. In May 2022, the practice had started piloting a system to call patients in for long-term condition monitoring and reviews in their birthday month. Achievement towards the targets was reviewed at weekly management meetings.
- The long-term condition searches indicated that patients were offered a structured review to check their health and medicines needs were being met in line with current guidelines.
- We saw that not all patients identified as having had two or more courses of oral steroids for asthma exacerbations in the last 12 months, had been followed up after their course of steroids to check if they had improved. However, they had been given clear safety netting advice. We saw that patients had had or been offered an asthma review within the last 12 months.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. A diabetes specialist nurse attended the practice every month to support patients with poor diabetes control. A mental health facilitator provided support for doing mental health reviews.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- 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) (NHS England and Improvement)	55	63	87.3%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	53	63	84.1%	Below 90% minimum

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	53	63	84.1%	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) (NHS England and Improvement)	54	63	85.7%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	31	45	68.9%	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

The practice had not met the minimum 90% target for all five childhood immunisation uptake indicators. However, four of the five indicators had improved slightly from the previous year. Staff described challenges around engaging with patients due to language barriers (both verbal and written), patients spending extended periods of time out of the country or patients moving locations and not notifying the practice.

The practice had sought to identify information leaflets on childhood immunisations in different languages. The clinical lead shared links to various websites and said they planned to use these leaflets in the future to help educate patients on the benefits of immunisations.

Systems were in place to follow up with parents when children were not brought for immunisations, share information with the health visiting service, and discuss at the safeguarding meetings as appropriate.

Cancer Indicators	Practice	CCG 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: 31/12/2021) (UK Health and Security Agency)	54.0%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	30.2%	40.1%	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)	40.4%	54.3%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	71.4%	56.4%	55.4%	No statistical variation

Any additional evidence or comments

Although the cervical cancer screening uptake was below the target of 80%, the uptake had steady increased during the last 18 months. Staff described the challenges around engaging with patients due to language barriers (both verbal and written) and patients spending extended periods of time out of the country. Staff tried to carry out opportunistic screening and health promotion when patients attended the practice for appointments.

Staff described the actions they were taking to try and improve uptake. A member of the administrative team had recently taken responsibility for contacting patients who did not attend appointments. The patients were contacted three times by telephone or letter and asked to complete a form if they declined to partake in the screening. This information was then shared with the national screening programme team. The text message sent to patients had been amended and referred to cancer screening as this terminology was better understood by the practice population. Staff thought that these changes had improved patient uptake.

Uptake of screening for breast cancer and bowel cancer was below the local and national averages.

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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

<p>The practice was conducting quality improvement projects and audits. Examples of audits seen:</p> <ul style="list-style-type: none">• Audit of antibiotic prescribing for urinary tract infections in women (One cycle – June 2022): This identified that 13 out of 16 patients had been prescribed antibiotics in line with the local antibiotic policy and guidance. Two patients had been given a longer course of antibiotics than would be recommended. One patient had been given an antibiotic that was not recommended in the local guidance. Improvements were identified to remind clinicians to check LMSG advice on antibiotic prescribing and duration of treatment.• Audit of patients on high dose opioids (Two cycle – Jan 2022 and March 2022): Two patients were identified. One patient was referred to the pain clinic. The learning from the audit was to use the Ardens opioid template to help manage patients on opioids, to offer patients a mental health assessment and to provide patients with opiate agreements regarding dose reductions.• Audit of the shared care agreement process for Attention Deficit Hyperactivity Disorder (ADHD) drugs (One cycle – June 2022): This showed that all patients on ADHD drugs had a shared care agreement in place and were up to date with monitoring checks and medication reviews. Improvements identified from the audit included recording shared care agreement and monitoring requirement details on the patient's home summary screen, setting up scheduled tasks for monitoring checks and recording shared care agreement details on prescriptions.
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Any additional evidence or comments

<p>The practice has also done some other quality improvement activities including:</p> <ul style="list-style-type: none">• Producing Medicines Optimisation newsletters and guidance (Jan – March 2022, May 2022): These included giving advice on recording the day of the week on which to take a specific medicine for rheumatoid arthritis on prescription in accordance with The Medicines and Healthcare products Regulatory Agency (MHRA) guidance, checking drug interactions advised against in MHRA safety alerts, calculating the creatinine clearance for patients on medicines used to prevent blood clots to ensure that they are on the correct dose and giving patients on medicines that may cause congenital malformations in babies contraceptive advice as recommended by the MHRA.• Maintaining a Medicines Safety Dashboard (Last updated in June 2022): This included checks for monitoring of high risk drugs and hypothyroidism, compliance with safety alerts and patients being prescribed more than 12 specific asthma inhalers in 12 months.• A diabetes project with an external company regarding use of medicines to lower blood sugar to

improve diabetes control. This had led to improvements as some patients had seen a reduction in their average blood glucose levels showing that their diabetes control had improved.

The practice was looking at doing other quality improvement projects including auditing renal patients and offering a joint back pain clinic with the physiotherapist.

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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us they were offered the opportunity to attend training and to further develop their skills. One member of staff was being supported to study towards the Nursing Associate Foundation Degree. Staff completed online essential training and attended regular protected learning afternoons.</p> <p>We saw that training opportunities for clinical staff were discussed at the clinical meetings and staff encouraged to attend.</p> <p>Staff received regular supervision and annual appraisals. The competency of all clinical staff was checked through regular audits of consultations and prescribing. For example:</p> <ul style="list-style-type: none"> • The pharmacist had regular debriefs with GPs regarding prescribing; • Prescribing was monitored centrally by the practice's parent organisation; • GPs and non-medical prescribers including agency staff were monitored by auditing consultations. • Evidence was seen of formal monitoring of competence with audits being done of GP consultations to identify areas for improvement including advice on using Ardens templates to record information and to document safety netting advice. <p>All staff completed a corporate induction programme, as well as site specific and role specific inductions. However, the practice was unable to show us a completed site and role specific induction for a newly appointment member of staff. Competency tools were used to assess the skills and knowledge of clinical staff.</p>	

The practice provided a resource pack in each consultation / treatment room, which contained useful information to assist staff to fulfil their role within the practice.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Clinical team meetings were held to share information every month. • Palliative care MDT meetings were held to discuss patients on the palliative care register. • Nearly all the healthcare services had access to SystmOne allowing patient records to be updated to facilitate information sharing between services. • Hospital correspondence was received electronically. • District Nurses could be contacted via tasks on SystmOne. • The practice had access to an Unscheduled Care Hub with staff who were familiar with supporting patient's social care needs. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us they had a good working relationship with organisations which supported patients with advice on healthy lifestyles, including weight management and smoking cessation.</p> <p>Patients identified with pre-diabetes and newly diagnosed diabetic patients were offered the opportunity to attend educational sessions relevant to their condition. These courses were available in a range of different languages, which helped to support the needs of the practice population.</p> <p>The practice had access to an onsite social prescriber who could signpost patients to services. A physiotherapist visited the practice once a week to support patients with musculoskeletal problems.</p> <p>There were 12 potential missed diagnoses of chronic kidney disease (CKD) identified through the searches. Five of these records were reviewed. One patient had CKD 3 which required annual kidney function monitoring with blood tests and urine albumin to creatinine ratio (ACR). This patient had not been coded as having CKD 3. The patient was having annual monitoring as they also had another long term condition and the nurse has asked the patient to provide a urine sample for ACR. Four patients had possible CKD 3, but needed repeat blood and urine tests to confirm the diagnosis. However, evidence was seen of the practice contacting these patients or scheduling tasks to arrange repeat checks.</p>	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff had attended mental capacity training and used Ardens templates to record mental capacity assessments.</p> <p>The practice told us that clinicians completed health and social care plans called ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) which targeted patients' wishes and the care they required. This incorporated an assessment of mental capacity and details of the patient's resuscitation status (for example, if cardiopulmonary resuscitation should be given or not).</p> <p>The practice did not currently have any patients for whom they had completed a ReSPECT form. We discussed providing the patient with a copy of the form once completed and ensuring that the patient knew to share the form with other health and social care professionals involved in their care and treatment.</p>	

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The provider understood the challenges associated with managing the service, and supporting the patients registered there. The leaders explained that the main challenges were: <ul style="list-style-type: none">• The high patient demand following the COVID-19 pandemic. The practice was planning to increase the number of face to face appointments being offered.• Educating patients (e.g. why it is important for them to have regular medication reviews).• High aggression levels from patients making staff recruitment an issue.• Large numbers of patients who do not have English as their first language meaning that GPs could have up to five patient contacts a day requiring an interpreter. This meant that consultations took longer adding to the GP workload. The practice was looking at providing letters in different languages to try to reduce the number of patients who did not attend appointments. Since the last inspection there had been further changes to the management support structure. The operational support provided had been strengthened and had been welcomed by the practice staff. A member of the operational support team was on site at least two days a week, and well as contactable for support and advice. The clinical lead also visited the practice at least once a week to support the GPs and nursing team.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence:	

The provider vision, strategy and values were displayed on the provider website. The vision and values were incorporated into the recruitment and appraisal process, to ensure that staff upheld the core values of the organisation.

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: Staff told us they were able to raise any issues or make suggestions, either during meetings or as issues arose, and they would be listened to and supported as required. Information about access to a Freedom to Speak up Guardian was visible in the practice.	

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

Source	Feedback
Staff interviews	Staff told us they enjoyed working at the practice and felt supported and valued by the management team. They said clinical and non-clinical staff worked well together as a team, and the GPs were supportive and approachable.

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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: The practice was supported by the wider organisation, and staff were clear about the roles and responsibilities within the organisational structure.	

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.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: Local governance procedures fed into the provider's overarching governance and oversight system and there was feedback to the practice staff. Relevant expertise such as safeguarding or infection, prevention and control was available from head office and supported local leads.	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: Patients were offered a range of appointments, including prebookable, urgent and on the day appointments. Patients were added onto a list and triaged by the clinicians. Face-to-face appointments were offered based on clinical need and were available in the morning and afternoon. The on-call GP	

was available to support reception staff with queries when all the appointments had been filled. A small number of appointments were available to book online.

Pre-bookable appointments were available to book with the practice nurse and the health care assistant for long term condition reviews, blood tests, cervical screening and childhood immunisations.

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The provider used performance information and audits to review and improve performance. The practice continued to monitor the uptake of long term condition reviews and medicine reviews.</p> <p>The provider was aware of the requirement to completed statutory notifications as required. However, we noted that an incident had occurred which resulted in contact with the police. The provider had not completed a statutory notification for this incident. This was discussed during the inspection and the provider agreed to complete the notification retrospectively.</p>	

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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: The practice had been unable to sustain the Patient Participation Group (PPG) during the pandemic and was looking to restart the group. The practice had introduced a number of initiatives to encourage patients to join the group which had been unsuccessful so far. A provisional date for an introductory meeting had been planned for July 2022. The practice was considering setting up listening groups for patients whose first language wasn't English and supporting them through interpreters and forming separate listening groups for female and male patients giving support and educational talks on specific topics, for example cervical cancer screening.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: There was a focus on learning and improvement, especially from significant events, complaints, clinical audits as well as staff training and development.	

Examples of continuous learning and improvement

There were regular clinical meetings to discuss improvements and learning. The monthly Protected Learning Time sessions provided an educational forum with expert speakers invited (e.g. to discuss guidelines on heart failure and managing frailty as well as support services available through the Children's Hospice). One of the GPs attended joint consultations with the practice's physiotherapist to help improve their

learning about managing musculoskeletal problems.

The practice felt it excelled at caring for and listening to patients. One of the GPs had supported patients getting food parcels demonstrating care for patients and leading by example.

Innovations included starting a project to support diabetes patients by initiating insulin treatment within the practice to help improve access to this treatment for patients and reduce the need to refer to specialist 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)	≤ -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.