

# Care Quality Commission

## Inspection Evidence Table

### The Community Practice (1-11293043775)

Inspection date: 29 November 2021

Date of data download: 09 November 2021

## Overall rating: Good

### Safe

### Rating: Requires Improvement

We have rated safe as requires improvement because:

- Not all medicine reviews for patients had been completed in line with guidance.
- We saw that two safety alerts had not been acted on appropriately.
- We found that there were some patients who had a potential missed diagnosis of diabetes.
- The prescribing of anti-microbials was above local and national averages.

#### 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>• Multi-disciplinary meetings discussions between other health and social care professionals such as health visitors, school nurses, community midwives, mental health professionals and social workers took place every month.</li><li>• Any learning from incidents was discussed at monthly 'Time to Learn' sessions.</li></ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>On the day of inspection, we looked at a sample of two staff files, both of which had recruitment checks carried out in accordance with regulations.</li> </ul>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 2 November 2021	Y
There was a fire procedure. Date of fire risk assessment: 4 January 2021	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The safety of the premises was shared between the owners of the building and the individual practices based there. There were clear lines of responsibility and this practice was clear on what their responsibilities were.</li> <li>Health and Safety risk assessments were carried out by the owners of the building on a monthly basis.</li> <li>Fire risk assessments were carried out by the practice.</li> </ul>	

## **Infection prevention and control**

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

	<b>Y/N/Partial</b>
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 23 September 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had remained open to patients throughout the pandemic, and they had continued to mitigate and monitor risks for staff and patients, safely and effectively.</li> <li>Evidence seen showed the practice followed national guidance to ensure effective infection control measures were followed throughout the pandemic.</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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>All staff had received sepsis awareness training and there were information posters in the clinical rooms.</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.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

## Appropriate and safe use of medicines

### The practice did not have 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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.91	0.77	0.69	-
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	18.2%	12.1%	10.0%	Variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	6.59	6.37	5.38	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	139.2‰	117.9‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.81	0.76	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	7.4‰	6.0‰	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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N
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.	N
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 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.	N/A
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set) (01/07/2020 to 30/06/2021) <sup>(NHSBSA)</sup>, was higher than local and national averages. The practice was aware of this and told us that a significant reason for this was that the local hospital discharged patients with prescriptions for these items. The practice had improved performance for this indicator since 2019.</li> <li>• Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021), was higher than local and national averages. The practice was aware of this data and similar to the above, a significant reason for this was that the local hospital was discharging patients with prescriptions for these items. The practice had improved performance for this indicator since March 2020.</li> <li>• The practice had carried out an audit of antibiotic prescribing in September 2021 in order that they could identify where improvements were required. We were satisfied that an improvement plan was in place.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>• During the remote clinical searches which we carried out, we found the following:               <ul style="list-style-type: none"> <li>➤ We identified that 23 patients were prescribed Methotrexate and of these, it appeared that 15 patients had not received the required monitoring. On the day of inspection, the practice was not able to access the hospital system and after the inspection, when the system was fully functioning, there was evidence to show that the patients had received the required monitoring.</li> <li>➤ We identified that 1107 patients were prescribed an ACE inhibitor or Angiotensin II receptor blocker. Of these it appeared that 344 patients had not had the required monitoring. Similar to the situation above, once the hospital system was functioning, we saw that most of these patients had received the required monitoring. Those that weren't were followed up immediately following the inspection. One patient was 18 months overdue for monitoring and the practice followed this up immediately after the inspection. Overall, the risks to patients were minimal as the required monitoring had been carried out, but was not available on the day of inspection.</li> <li>➤ We identified that 93 patients were prescribed Apixaban. Of these we found that one patient was potentially at risk as the required monitoring had not taken place. This was addressed immediately after the inspection and it was found that the patient had received the correct monitoring, but it was not available on the day of inspection.</li> <li>➤ We found that there were 14 patients with a possible missed diagnosis of diabetes. The practice followed up these patients immediately after the inspection and the practice had put in place a more effective system for identifying patients with a possible diagnosis of diabetes.</li> <li>➤ We identified that the monitoring of patients who were prescribed Azathioprine was satisfactory.</li> <li>➤ We examined medication reviews for five patients, and all were satisfactory.</li> <li>➤ We examined a sample of six patient records who were prescribed SABA inhalers, and all were satisfactory.</li> </ul> </li> <li>• In conclusion, we found that medicine reviews were being carried out effectively for the majority of patients, however, some strengthening to their systems was required.</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:	Seven
Number of events that required action:	Seven
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Staff we spoke to told us that they felt confident and comfortable raising a significant event.</li> </ul>	

- Staff also told us that the learning from significant events was shared and that there was a no-blame culture around this.

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

Event	Specific action taken
A member of staff found a vial of blood on their desk which had been found by one of the cleaning team. The vial had patient details on it and had dropped out of the pathology specimen bag on collection.	Staff member immediately alerted management and checked that the other vials in the same collection had been received by pathology. The vial that was found was re-sent to pathology, aware that it might have been too late to be tested. The system was checked, and the sample was usable. This incident was reviewed and discussed, and it was decided to carry on with the current system of collection, but to make sure that the collection bags were secure each day at the time of collection.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Although the practice had a system in place to record and act on new safety alerts, we found that there were two safety alerts which had been issued in the past which had not been acted on. Both alerts related to the co-prescription of medicines, which should have ceased. We found that there were 21 patients in total who were co-prescribed these medicines at the time of inspection. We examined 11 of these patient records and found that nine needed to be reviewed. The practice addressed this issue immediately after the inspection. In conclusion, we found that there was a system in place to review safety alerts, but it required some strengthening.</li> </ul>	

## Effective

## Rating: Good

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

## Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had introduced a triage system which automatically allocated patients into one of four groups, according to vulnerability. Clinicians told us that was an effective way to prioritise which patients to call back first.</li> </ul>	

## Effective care for the practice population

Findings
<ul style="list-style-type: none"> <li>The practice had a register of older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. Older people were a priority group in the triage appointment system.</li> <li>Health checks, including frailty assessments, were offered to patients over 75 years of age, including throughout the pandemic period.</li> <li>Flu, shingles and pneumonia vaccinations were offered to relevant patients.</li> <li>The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li> <li>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.</li> <li>All patients with a learning disability were offered an annual health check.</li> </ul>



- 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 demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- We saw evidence that clinicians regularly worked with other organisations to provide multi-disciplinary care and treatment.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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. However, during the remote clinical searches, we saw that there were fourteen patients with a possible missed diagnosis of diabetes. This was addressed immediately after the inspection.
- 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) (01/04/2019 to 31/03/2020) (NHS England)	29	29	100.0%	Met 95% WHO based target

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	24	27	88.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	24	27	88.9%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	24	27	88.9%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	29	30	96.7%	Met 95% WHO based target

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 continued to recall children to have their vaccinations throughout the pandemic. Data showed that three indicators were just below the minimum target. However, the practice's more current unverified data showed that they were achieving the minimum target of 90% or above for these indicators. The practice had improved performance for this indicator since 2019.
- Clinical staff demonstrated that an effective recall process was in place at the time of inspection, which included taking appropriate safeguarding action if necessary.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/03/2021) (Public Health England)	73.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	71.9%	70.2%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	62.0%	65.4%	63.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two	44.4%	54.1%	54.2%	No statistical variation

week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)				
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### Any additional evidence or comments

- The practice was aware that their data for 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). (Snapshot date: 31/03/2021) (Public Health England), was below the national average and they had a plan in place to increase the number of women being screened. Staff acknowledged that some women had been hesitant to attend the surgery during the pandemic and they were taking action to encourage women to visit the surgery again.

### 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

We saw evidence of completed quality audits and a programme of audits to be completed during 2022, including:

The practice had carried out an antibiotic audit in July and August 2021. The aims were:

- To identify and review high risk antibiotic prescribing at the Practice.
- To reduce the prescribing of high-risk antibiotics linked with Clostridium difficile infection (CDI).
- To encourage antibiotic prescribing in line with local guidelines.
- Achieve 10% (or below) for the number of high-risk antibiotics (cephalosporins, quinolones and co-amoxiclav) prescribed (as a percentage of total antibiotics prescribed). The audit found that the current figure was 16%.

- The results of this audit were shared with the prescribing clinicians at the practice as a learning opportunity for clinicians to reflect on their prescribing data.
- An interactive training session with a microbiologist speaker was set up (community nurses were invited).
- Clinicians were encouraged to document clearly their indication for choosing a high-risk antibiotic (i.e. high risk of treatment failure)
- Clinicians were encouraged to utilise laboratory testing and/or a discussion with a microbiologist before opting for a high-risk antibiotic.
- This audit was scheduled for review and further monitoring/auditing was carried out. The aim was to reduce the percentage of high-risk antibiotic prescriptions to the target 10% of all antibiotics prescribed by the practice.

The practice established an infection control audit schedule for the period September 2021 – September 2022. The aims of this were:

- To measure the quality of the service and ensure that the governance arrangements in place are robust and effective.
- To discuss the results at practice governance meetings with actions required clearly outlined and reviewed to determine its effectiveness.
- The result of the initial environmental audit was that no actions were required.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centered care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice is situated in a building which also accommodates other healthcare providers, including the offices of the Primary Care Network (PCN), phlebotomy services, district nurses, palliative care nurses and others. On the day of inspection, we saw evidence that the practice had forged good working relationships with these providers to deliver coordinated care and treatment to patients.</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

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Clinical records searched during the remote clinical searches showed that consent was obtained. Clinicians explained the process used at the practice to obtain consent.</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-judgmental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

### Patient feedback

Source	Feedback
One patient on site at the practice	<ul style="list-style-type: none"> <li>The patient we spoke to told us that staff were always helpful. They said that they felt that the infection control measures in the practice made them feel protected from inspection. They told us that they received excellent care from the clinicians.</li> </ul>

### National GP Patient Survey results

Indicator	Practice	CCG 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	87.6%	86.4%	89.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)				
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 (01/01/2021 to 31/03/2021)	87.8%	84.7%	88.4%	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 (01/01/2021 to 31/03/2021)	95.6%	94.6%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	74.6%	79.5%	83.0%	No statistical variation

Any additional evidence
<ul style="list-style-type: none"> <li>The practice had presented the National GP Survey Data at the most recent Patient Participation Group (PPG) meeting and were working with them to create a patient feedback tool to be used in 2022.</li> <li>The PPG included local councillors and the group was very active and provided patient feedback to the practice regularly.</li> <li>Feedback from the PPG about the practice was very positive.</li> </ul>

### 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>Easy read and pictorial materials were available to support staff with explanations of care and treatments when appropriate.</li> </ul>	

### National GP Patient Survey results

Indicator	Practice	CCG 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 (01/01/2021 to 31/03/2021)	86.7%	91.4%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> <li>The practice had identified 110 carers which equates to 1.7% of the practice population.</li> </ul>
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>The practice had a carers' champion, who had undertaken additional training. They were working in partnership with the wellbeing link coordinator and local carers charities to support carers.</li> <li>The practice had developed a new template to identify carers who were then given a code on the clinical system, which enabled them to be included in offers of support or messages of information.</li> <li>Identifying and supporting carers was on the agendas of the monthly time to learn and clinical meetings to raise awareness and encourage more read-coding.</li> <li>Carers were offered an annual health assessment.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>The practice worked in partnership with the palliative care team who were co-located in the same building, to deliver personalised care to recently bereaved patients.</li> <li>The practice also provided details of local support services.</li> </ul>

## 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
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# Responsive

Rating: Good

## Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Patients were able to access appointments during the day on Saturday and Sunday 10 am – 1pm, at two local practices which had to be pre-booked via the practice.	

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 6.30pm Monday to Friday. Pre-bookable appointments were also available to all patients at additional locations within the area on Saturday and Sunday 10am until 1pm.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

### Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y

The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice had remained open throughout the pandemic and offered appointments in line with guidelines as they were issued.</li> <li>The practice had a telephone triage system which automatically categorised patients into one of four categories, which enabled clinicians to see at a glance who the most vulnerable patients were and enabled them to prioritise their assessments if necessary.</li> <li>The practice used mainly face to face and telephone appointments.</li> </ul>	

### National GP Patient Survey results

Indicator	Practice	CCG 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 (01/01/2021 to 31/03/2021)	57.8%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	66.0%	66.0%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	57.9%	63.4%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	74.9%	80.8%	81.7%	No statistical variation

Source	Feedback
CQC Enquiries	<ul style="list-style-type: none"> <li>Three complaints were received in the previous 12 months. One related to being unhappy with the triage system, one related to a delay in replying to correspondence and one related to care provided.</li> </ul>

## 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.	61
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Complaints were recorded and documentation was maintained to assure practice patients received an appropriate and timely response.</li> <li>Complaints were discussed in practice meetings and the learning was shared.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint about communication with reception staff.	Management listened back to the call with the staff member concerned, discussed the situation and implemented some further training. The patient's needs were addressed, and a written apology was sent. The learning was shared.
Complaint about difficulty in obtaining prescription for repeat medication.	The practice sent a detailed written explanation as to what had gone wrong and apologised. The situation was rectified, and the learning was shared.

## Well-led

## Rating: Good

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y

There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>We saw evidence that the practice was working with external partners to improve quality and sustainability, including the Clinical Commissioning Group (CCG), community care providers and local hospitals.</li> <li>The practice leaders had a draft plan for the future staffing in place, including clinical staff.</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:	
<ul style="list-style-type: none"> <li>The practice leaders had acted to ensure that the practice was a key part of the local community.</li> <li>Staff engaged with local community activities and made use of local facilities to deliver healthcare services.</li> </ul>	

## 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:	

- Staff we spoke to told us that they felt comfortable to raise concerns with leaders without worrying and that they were encouraged to raise any issues at any time without the need to wait for a formal meeting.

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

Source	Feedback
Staff conversations	Staff we spoke to told us that the practice was a good place to work and that they felt supported and valued. They told us that they were given adequate time to carry out their roles effectively. They told us that the lead GP placed a lot of emphasis on the work-life balance of the staff team.

### Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<ul style="list-style-type: none"> <li>• We saw well-led governance structures within the practice which ensured the effective cascade of information to the clinical and non-clinical teams.</li> <li>• Quality improvement sessions were held each week which enabled development within the areas of responsibility.</li> <li>• Lead roles were allocated to the clinical and non-clinical staff. There were regular meetings to assure oversight and accountability within the practice.</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
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**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.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice provided continuous care throughout the pandemic and continued to do so, with a choice of appointments offered to patients.</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>We saw evidence of completed quality audits and a programme of audits to be completed during 2022.</li> </ul>	



## 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

## Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice worked with the CCG to drive high quality care.</li> <li>The practice worked with a wide range of other health and social care providers to provide multi-disciplinary care and treatment.</li> </ul>	

### Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> <li>The feedback from the PPG was positive and supportive of the practice.</li> <li>Some members of the PPG had assisted on a voluntary basis with flu and COVID-19 vaccination clinics.</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>We saw that staff members had been given the opportunity to learn specialist skills to enable them to improve the services offered to patients.</li> </ul>	

## Examples of continuous learning and improvement

- Staff were given protected learning time.
- Some staff had designated areas of responsibility and were given additional training to enable them to fulfil their roles.

### 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 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.
- **PHE:** Public Health England.
- **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.
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- ‰ = per thousand.