

Inspection Evidence Table

The Broadshires Health Centre

(1-550038747)

Inspection Date: 29 June 2023

Date of data download: 19/06/2023

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

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

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

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>As a result of the inspection the practice adjusted their staff vaccination protocol to include prompting the annual flu vaccine to their staff. All other vaccinations recommended by the Green Book (national guidance) were included in the practice's existing protocol.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: Various assessments	Y
There was a fire procedure.	Y
Date of fire risk assessment: December 2021	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a fire risk assessment and actions had been completed such as fire extinguisher and fire alarm checks. There was an action to complete regular fire drills and this had not yet been completed. The manager was aware of this and had planned a fire drill in July 2023.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met/not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: January 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an equipment cleaning audit to ensure items stored in areas such as consultation rooms were periodically cleaned.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence:	
Reception staff had access to reference information to identify high risk concerns and if these were reported by patients they had processes to prioritise based on risk factors.	

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 had systems for the appropriate and safe use of and prescribing of medicines.

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	1.15	0.77	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) * (NHSBSA)	12.1%	9.7%	7.8%	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 (01/10/2022 to 31/03/2023) (NHSBSA)	5.94	5.07	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	107.6‰	87.9‰	129.8‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.22	0.36	0.55	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	4.5‰	5.4‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial
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.	Partial

The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The majority of patients prescribed high risk medicines received appropriate monitoring including blood tests where necessary. There was a process in place for identifying patients who did not have up to date monitoring of their medicines and recalled these patients. The practice had implemented the monitoring tools in recent months and were assessing their introduction. A clinical pharmacist supported the practice in undertaking the monitoring of prescribing. If the patients did not attend then the patients were put on acute prescriptions (non-automatic repeat prescriptions) until they attended for monitoring. For example,</p> <p>-Of 70 patients prescribed Methotrexate (often used to treat cancers, rheumatoid arthritis and psoriasis), 2 were overdue monitoring. The practice was aware of these patients and was making efforts to undertake the patients' monitoring.</p> <p>-We found 10 of the 47 patients prescribed direct-acting oral anticoagulants did not have up to date monitoring via blood tests to ensure their prescribing was safe. Of the 5 patients we reviewed 2 were overdue their tests by two months and another patient was one month overdue but had been recalled for a blood test.</p> <p>*The practice informed us that during the Strep A outbreak in winter 2022/23 there was a shortage of the preferred type of antibiotic prescribed for treating this infection. Therefore alternative medicines were prescribed which accounted for the number of prescription items for co-amoxiclav, cephalosporins and quinolones. (Strep A is a common type of bacteria which usually leads to mild infections which are easily treated, but some infections are more serious).</p>	

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: 6 (new review and recording system implemented in September 2022).	Y
Number of events that required action: 6	Y

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Cold chain breach: fridge door left open and medicine stocks were compromised.	The medicines were quarantined from other stock and Public Health England were informed. Stock was destroyed or used off-license as recommended by guidance. Additional checks were implemented to reduce risk of cold chain breaches.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Some prescribed medicines subject to risks associated with medicine safety alerts were not monitored appropriately. For example, patients prescribed teratogenic medicines who were of childbearing age were not always made aware of the associated risks (these are a variety of medicines which may lead to birth defects). However, of the patients we reviewed prescribed this medicine type, 4 were using contraception and 1 was not on contraception and therefore at current risk.</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.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
The nursing team had implemented a single process and protocol document for assisting the nurses in assessing patients effectively and safely. For example, there was quick reference information for analysing blood pressure readings and what action should be taken immediately or if further monitoring was required. This enabled staff to provide consistent assessments of patients needs and reduced the requirement to ask GPs for advice. The document also ensured processes were followed for reviews of diagnostic tests such as ECGs (Electrocardiogram; used alongside other tests to help diagnose and monitor conditions affecting the heart), where a GP needed to review the test results quickly.	

Effective care for the practice population

Findings
<ul style="list-style-type: none">• Flu, shingles and pneumonia vaccinations were offered to relevant patients.• There were 41 patients with a learning disability registered at the practice and of those 37 had a health check undertaken between April 2022 and March 2023.• End of life care was coordinated with other professionals and providers as needed.• Local care homes were provided with regular GP visits and responsive care where necessary.• The practice assessed and monitored the physical health of people with mental illness and ensured they had up to date care plans in place.

- Healthcare checks and screening for serious conditions was offered and facilitated by the practice. For example, clinics outside of normal working hours were offered for cervical screening.

Management of people with long term conditions

Findings

The clinical searches we performed on the provider's clinical record system identified that patients with the highest risk of complication caused by their conditions were being monitored appropriately. For example,

- Diabetic patients who had associated risks with deterioration of their eye health, had the appropriate monitoring in place.
- Patients prescribed rescue steroids related to exacerbation of Asthma had the appropriate follow up care. Of 5 patients we reviewed who had been prescribed rescue steroids all had received appropriate reviews and 4 had been issued with a steroid card to provide them with pertinent information.
- There were 312 patients with hypothyroidism of whom 12 had no thyroid function test monitoring for 18 months. We reviewed 5 of these patients and found the practice was aware of 3 patients with overdue monitoring and was actively attempting to recall the patients. The practice informed us they would recall the remaining two patients.
- There were 28 patients with chronic kidney disease listed registered at the practice, of whom 3 were overdue monitoring. We found no risks associated with the patients care when we reviewed their clinical records in detail.
- The practice was monitoring patients at risk of undiagnosed conditions. For example, there were 2 patients at risk of developing diabetes identified from our searches and the practice had been monitoring them appropriately.

The nursing team had a variety of specialisms including respiratory care and diabetes care. Nurses were supported to undertake long term condition reviews by recall systems managed by administration staff, healthcare assistants who could undertake clinical observations and diagnostic tests and GPs for advice.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	176	180	97.8%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	210	220	95.5%	Met 95% WHO based target

Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	209	220	95.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	210	220	95.5%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	178	191	93.2%	Met 90% minimum

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

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	77.8%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	72.8%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Data snapshot: 31/12/2022) (UKHSA)	76.6%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	57.9%	58.4%	54.9%	No statistical variation

Any additional evidence or comments
Data supplied by the practice, collected between from April 2022 to March 2023 identified that 80% of eligible patients had a cervical screening within the recommended timeframe.

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: The practice undertook an audit on interventions and monitoring for patients prescribed dependency forming medicines (DFMs) from January to March 2023. The initial search identified that 12% of patients had a structured medicine reviews in line with guidance. Following work to ensure reviews took place, the next audit cycle identified 53% of patients had a structured review. The final audit cycle, concluded with 58% of patients on DFMs having their prescribing safely stopped. The practice undertook an audit of patients who may have not been coded/recorded on the clinical system where they had a diagnosis of gestational diabetes (diabetes which can form during pregnancy and may lead to an increased risk of forming diabetes later in life, therefore patients require period monitoring). Of 33 patients included in the audit from June 2023, 7 were found to have a missed diagnosis and were added to the register of patients with gestational diabetes. The audit also identified that of the 88 patients on the register, 56 patients had not had a specific blood test in the last 12 months to screen for potential development of diabetes. This led to all the patients requiring blood tests having prompts sent to them to attend for screening. Within 1 week, 20 patients had attended for a diabetes blood (Hba1c) test. Subsequent prompts were sent to patients who had not attended for screening. The audit was planned biannually to ensure check the extent of monitoring for diabetes in this patient population.	

Effective staffing

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

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

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
The practice was implementing a new appraisal system for staff following a period of time when appraisals had not been undertaken routinely. Staff who had been appraised with the new process commended the supportive nature of the reviews and stated they were able to pursue development where this was mutually beneficial to them and the practice.	

Coordinating care and treatment

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

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

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 / was unable to demonstrate that it 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	
The practice's lead GPs explained the process for reviewing DNACPRs. The practice provided evidence of 2 examples we requested where DNACPRs had been reviewed with inclusion of the patient or/and significant other persons, such as relatives.	

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 (none available from 1pm to 2pm)
Tuesday	8am – 6:30pm (none available from 1pm to 2pm)
Wednesday	8am – 6:30pm (none available from 1pm to 2pm)
Thursday	8am – 6:30pm (none available from 1pm to 2pm)
Friday	8am – 6:30pm (none available from 1pm to 2pm)

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> • 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. • There was a medicines delivery service for housebound patients. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. • Additional appointments were available until 8.30pm on Tuesdays and cervical screening appointments were offered to suit those who worked full time. • The practice had alerts on the clinical system to identify patients who had specific needs such as disabled patients or those with sensory impairments. • Homeless patients or those with no fixed address could register at the practice to access care and the practice informed us they managed these patients correspondence using the practice's address. • There was a hearing loop, large text information was available and other communication in various formats support was available. • Language translation services were available. • The practice had a neuro-diversity lead who was able to support patient with autism and learning disabilities. For example, a patient with learning disabilities had a significant fear of attending the practice and the lead member of staff helped the patient overcome their fears by meeting outside the practice for reassurance and gradually introducing them to the practice. • The practice had access to a mental health charity worker who they could refer patients to.

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Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	55.5%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	55.6%	64.1%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	51.5%	59.6%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or	68.1%	76.9%	71.9%	No statistical variation

appointments) they were offered (01/01/2022 to 30/04/2022)				
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Any additional evidence or comments

The practice was aware there was a lack of appointments to meet patient demands. Therefore they introduced a greater variety of appointments to reduce the demand on GP appointments, including a range of nursing appointments and advice for patients to access pharmacy care where necessary. Reception staff reported that where a patient call back was required, GPs would ensure a call back was made the same day. Urgent appointments were provided, based on criteria and reception staff had training and guidance to ensure appropriate allocation of appointments. Due to a reduction in GPs since 2021, the GP partners had recruited long term locums and salaried GPs to increase clinical care capacity

Source	Feedback
NHS.uk website (formerly NHS Choices)	3 reviews last 2 months: 2 reviews were 5 star ratings and very positive. 1 review was a 1 star rating with negative feedback about accessing appointments.
Healthwatch Oxfordshire	3 reviews in June 2023 all with 5 star ratings.

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.	14
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.	1 (of those we reviewed)

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

Example of complaint.

Complaint	Specific action taken
A patient raised multiple concerns related their experiences of receiving care.	The practice investigated each element of the complaint and provided feedback on their investigation. Where they identified fault, an apology was issued. The practice made efforts to ensure to rectify the issues reported by the patient.

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:	
The practice had lost a manager and 4 partners in the previous 2 years. The remaining 2 GP partners identified the main priorities in ensuring the future of the practice and maintaining services. They worked constructively with commissioners to plan for the future delivery of services.	

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:	
The two partners identified the highest risks to the sustainability and safety of the service and recruited a new manager. They implemented a strategy to recruit a new practice manager, ensure the long term financial security of the practice and improve services for patients.	

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 spoke passionately about their part in delivering services to patients. They informed us they felt empowered to be proactive and innovative by the leadership team. For example, the nursing team had identified improvements to care delivery and monitoring of infection control and emergency medicines.	

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

Source	Feedback
Staff interviews	Staff reported an open and supportive culture at the practice. They told us leaders were visible 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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
The practice had undertaken work to identify ineffective governance processes and where needed they made improvements. For example, they reviewed policies and protocols and improved those used for reception staff	

and nursing care. Clinical governance processes were still in the process of being improved. There were clinical audits being planned. The processes to manage long term conditions and monitoring of repeat prescribing were not yet finalised but progress had been made in ensuring care was safe for patients.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
As part of the improvements to governance, the practice identified where some risks were not managed effectively. For example, where legionella risk assessment had identified actions, these were not monitored appropriately in 2022. The practice created monitoring tools to ensure such tasks were completed when needed.	

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

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 (PPG).	Y

Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Feedback from PPG

The practice was in the process of recruiting a PPG, but this was challenging due to the transient nature of the patient population. There were some patients interested in forming a group. The practice had created a reference group of patients to contact for feedback going forward.

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.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement

The nursing team had implemented a single process and protocol document for assisting the nurses in assessing patients effectively and safely. For example, there was quick reference information for analysing blood pressure readings and what action should be taken immediately or if further monitoring was required. The document enabled a healthcare assistant to appropriately deal with a cold chain breach in the absence of any nurses, because they could follow the steps listed in the quick reference guide. This protected patients from risks associated with poor cold chain management.

A new appointment booking process had been implemented to provide a diversity of appointment types with different specialisms within the practice. Reception staff had patient pathway guidance to assist them in allocating patients to various appointments. This made the system more efficient and had led to a significant decrease in poor feedback regarding appointment access. A new telephony system was due to be procured to improve phone access.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands. The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

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

The following language is used for showing variation:

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

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

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

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

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

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

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

Glossary of terms used in the data.

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