

## Inspection Evidence Table

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(1-572669383)

Inspection Date: 25 October 2023

Date of data download: 24/10/2023

## Overall rating: Requires Improvement

We have rated the practice as requires improvement overall as we found safety and governance systems and processes needed strengthening to mitigate risk.

## Context

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the second lowest decile (seven of 10). The lower the decile, the more deprived the practice population is relative to others. According to the latest available data, the ethnic make-up of the practice area is 98.8% White, 0.6% Asian, 0.6% Mixed and 0.1% Black. The age distribution of the practice population closely mirrors the local and national averages. There are more male patients registered at the practice compared to females.

## Safe

## Rating: Inadequate

We have rated the practice as Inadequate for providing safe services as we found systems and processes required strengthening to ensure patients received the appropriate care and treatment. This included systems for safeguarding patients, infection control procedures and the actioning of safety alerts.

### Safety systems and processes

**The practice had some 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.	N
Partners and staff were trained to appropriate levels for their role.	Partial
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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>On reviewing staff training we found not all staff completed training which was appropriate to their role, this included both clinical and non-clinical staff.</li> <li>We reviewed 3 sets of minutes from clinical meetings, 2 sets of minutes from staff meetings and found no evidence to demonstrate that safeguarding was a standing item for discussion to highlight any ongoing concerns with staff to ensure all staff were aware.</li> <li>We carried out a review of the safeguarding registers and found alerts had not been added to some patient records to highlight safeguarding concerns. We found family records were not linked to advise staff there were safeguarding concerns within the family.</li> <li>The practice told us they had no safeguarding meeting schedules in place; however, they had access to the local safeguarding team if they needed to raise any concerns. The leadership team said they had tried to liaise with the health visiting team, however had been unsuccessful.</li> <li>Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks were in place for staff as part of pre-employment checks. This included enhanced and standard DBS checks based on the role and responsibilities of the job. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.</li> <li>The practice had policies and processes to support staff in this area and staff were clear on how they accessed these policies.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We looked at a range of recruitment files which included both clinical and administrative employed staff and found appropriate recruitment checks in place.</li> <li>We found outstanding immunisation status for 2 clinical staff. We were told that all staff before commencing employment were asked to provide immunisation status or attend occupational health for the appropriate tests. However, we found no evidence to demonstrate this had been actioned. Following the inspection, we received evidence to demonstrate that 1 of the clinical staff identified on the day of inspection had provided their immunisation status.</li> </ul>	

Safety systems and records	Y/N/Partial
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Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment: September 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment:	N
Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• A fire inspection certificate of the fire alarm system was provided. This was dated August 2023.</li> <li>• No evidence was provided to demonstrate a fire risk assessment had been completed.</li> <li>• On reviewing staff training we found one of the leadership team had not completed office safety training, a member of the administration team was not up to date with fire training.</li> <li>• The practice told us that fire alarm testing should be done on a weekly basis, however this was dependant on staff availability. We found no evidence to demonstrate there was a rota system in place to ensure the alarms were tested weekly.</li> <li>• The health and safety assessment had found there was no annual review of the health and safety policy and had not been signed and dated by the person with overall responsibility for health and safety at the practice. At the time of the inspection, we found no evidence to demonstrate this had been actioned.</li> <li>• Evidence provided by the practice showed equipment was regularly calibrated and electrical items were PAT (portable appliance testing) tested.</li> </ul>	

### Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Partial
Date of last infection prevention and control audit: August 2022	N
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The last infection control audit had been completed in August 2022, when the practice had achieved 93% overall score.</li> <li>• On reviewing the practice policy this had last been updated in July 2022. We received no assurances that this was due to be reviewed or updated. Following the inspection, we were provided with evidence to demonstrate that the practice policy was not due to be renewed until July 2024. However, on reviewing the policy we found it still had not been updated. For example: The infection control lead listed in the policy no longer worked at the practice and links to further information did not exist.</li> <li>• The infection control lead had received no advanced training in order to be able to do this role effectively. We were told there was no clinical support for this role.</li> </ul>	

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**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.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• A rota system was in place to manage staffing. At the time of the inspection, the practice told us they had been trying to recruit an extra practice nurse but had not been successful. Due to the nursing shortage, long term condition clinics were constantly full. The practice was currently employing 2 locum nurses to provide immunisation and cervical screening appointments.</li> <li>• Systems were in place to ensure emergency medicines were checked on a regular basis.</li> <li>• On reviewing staff training we found some staff had not completed sepsis awareness training. There was a poster on display to advise staff of what to do in an emergency.</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
<p>Explanation of any answers and additional evidence:</p>	

- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- There was a system in place to ensure all patient information including documents, laboratory test results and cytology reports were reviewed and actioned in a timely manner.
- We found that test results were managed in a timely way and all workflow was followed up and actioned appropriately.

### Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.89	1.03	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). (01/07/2022 to 30/06/2023) (NHSBSA)	11.4%	7.3%	7.8%	Tending towards 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 (01/01/2023 to 30/06/2023) (NHSBSA)	4.84	5.20	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	120.6‰	169.7‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.36	0.56	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	4.2‰	7.6‰	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.	N
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Partial
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.	Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial
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:</p> <ul style="list-style-type: none"> <li>We carried out a range of clinical searches to identify patients who had received a medicine review in the past 3 months. We found 671 patients who had received a review. We carried out a review of a random sample of 5 patients and potentially found 2 patients who had insufficient information on their medicine review.</li> <li>Medicines were stored safely and securely. Access to the dispensary was limited to authorised staff only.</li> <li>The storage of controlled drugs was not in accordance with best practice guidance. The cabinet did not have a robust multiple point lock; it could not be assured it was secured to a wall and fixed with bolts that are not accessible from outside the cupboard.</li> <li>There was no protected time in the appointment list for a new clinical pharmacist to general practice to have mentoring and feedback on consultations. There was no evidence of clinical supervision when asked.</li> <li>There were written standard operating procedures in place for the management of controlled drugs. However, these were not always followed.</li> </ul>	

- Individual controlled drug registers were not correctly completed with all the medicine information required. We also found entries were crossed out in the registers and balance checks were not being completed.
- The controlled drug keys were stored in a key code lock. The staff said the key code was never changed.
- Staff, when asked about the NHS Controlled Drugs Accountable Officer, could not provide information on who this was nor where they would find this information. They were not aware this information was in the controlled drugs register.
- A missed entry was noted in the controlled drug register. When brought to the staff's attention there was no note that it was a missed entry when entered.
- Blank prescriptions were all recorded and stored safely and securely. There was a record of each batch in use. The printers all had a lock on the prescription drawer.
- The practice had a standard operating procedure (SOP) for medicines monitoring for patients on high-risk medicines (warfarin, lithium, DMARDs) From the clinical searches we conducted for patients on high-risk medicines (warfarin, lithium, DMARDs), they were mostly up to date on monitoring.
- The practice was now monitoring its prescribing of antibiotics and had taken steps to reduce the overuse of these to reduce the risk of adverse events and antimicrobial resistance. A senior partner who has retired was given as the reason for the data being higher than the national average.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Partial
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Partial
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	N
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Partial
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Partial
Explanation of any answers and other comments on dispensary services:	

- Medicines training for dispensary staff did meet national guidance. However, dispensary staff competencies were not being reviewed and assessed by the practice.
- There were standard operating procedures (SOP) for processes in the dispensary. These were however missing information such as the date when signed by staff. There was no approval date and no name of who had approved the SOP.
- Fridge temperatures for the dispensary fridge had not been recorded daily over many months. The maximum and minimum temperatures were not always recorded correctly with the same temperature recorded for both.
- On an occasion when the maximum temperature was recorded outside of the recommended guidelines no recheck was done and we found no evidence to demonstrate that this had been reported. We were therefore unable to gain assurances that medicines would have their desired effects when administered.
- There was no specific area for dispensers to talk confidentially to patients and provide advice. This would be offered at the hatch that went outside to the back of the practice.
- There was no written guidance for medicines not to be included in Monitored dosage system (MDS) packs. Dispensers used their own knowledge on which medicines to not put in. On speaking with the clinical lead, we were told that staff could contact the medicines management pharmacists' team if needed. This was not included in the SOP. We found the current processes needed strengthening to ensure dispensary staff had a list of medicines not to use in MDS packs.
- Date checking for medicine stock was done every 4 months, however this did not follow the SOP which stated it should be done every month.
- Any dispensing incidents or errors were recorded, and evidence was provided.

**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:	5
Number of events that required action:	5
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses.</li> <li>• Significant events were discussed at clinical governance meetings. Evidence provided showed the last meeting had been held in September 2023.</li> </ul>	



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

Event	Specific action taken
Disruption of electricity supply	<ul style="list-style-type: none"> <li>• Manual procedures were put in place</li> <li>• Communication with external agencies was completed, this included wastage of vaccines.</li> <li>• Disaster recovery automated telephone message was activated.</li> <li>• Incident communicated to patients.</li> </ul>
Scanned letter added to the incorrect patient record	<ul style="list-style-type: none"> <li>• Practice staff noted the letter had been scanned onto the wrong patient record and removed it.</li> <li>• Action plan was implemented to ensure before scanning information onto patients' records were double checked.</li> </ul>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was an Excel spreadsheet given by the PCN technician for new drug safety alerts to GPs. Records of actions taken, by which member of staff, and on what date were not recorded on this spreadsheet by the practice.</li> <li>• Clinical searches showed drug safety alerts were not always actioned. For 1 alert 0 patients from a selection of 5 did not have any information regarding discussion around the alert in their records. With another alert, 3 patients out of 5 did not have sufficient detail recorded. CQC cannot be assured that safety alerts are acted on in a timely manner with clear processes.</li> <li>• No evidence was available to show how other clinicians in the practice were made aware of drug alerts in a timely manner and actions to take.</li> </ul>	

## Effective

## Rating: Requires Improvement

We have rated the practice as requires improvement for the effective key question as reviews of patients with long term conditions needed strengthening to ensure they received the appropriate monitoring and we identified gaps in staff training.

*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.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>Our clinical searches found the majority of patient's care and treatment was regularly reviewed and monitored for example, high risk medicines. However, searches of the clinical system showed 24 patients with asthma had been prescribed 2 or more courses of rescue steroids in the past 12 months. We reviewed a random sample of 5 of these patient's records and found all 4 patients requiring high dose steroid treatment for severe asthma episodes had not been followed up in line with national guidance.</li></ul>	

- Patient care plans had been shared with other organisations when appropriate.
- Clinicians accessed training and updates relevant to their roles to keep them up to date. They could access clinical guidance through the National Institute for Health and Care Excellence (NICE).

## Effective care for the practice population

### Findings

- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice 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.
- The practice had a care co-ordinator in place who was also the learning disability champion. They monitored the clinical register and sent out invitations for annual review to patients.
- The practice had access through the primary care network to a mental health practitioner who held a regular clinic at the practice.

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with COPD were offered rescue packs.

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)	34	34	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	38	38	100.0%	Met 95% WHO based target
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)	38	38	100.0%	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)	38	38	100.0%	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)	37	38	97.4%	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>

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)	77.2%	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)	74.8%	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). (3/31/2023 to 3/31/2023) (UKHSA)	81.3%	N/A	80.0%	Met 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)	50.0%	59.4%	54.9%	No statistical variation
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**Any additional evidence or comments**

The practice had tried to recruit a second practice nurse, but at the time of inspection had been unsuccessful. To ensure patients continued to have access to appointments for immunisations and cervical screening, 2 locum nurses were providing clinics.

### 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
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:  An audit of patients on medicines used to control high blood pressure had been completed to check if the appropriate monitoring had taken place. Clinical guidance recommendations where renal function and serum electrolytes should be checked 1 to 2 weeks after starting treatment and 1 to 2 weeks after each dose increase. The audit looked at the last 50 patients and found 42 patients had blood tests completed within 2 weeks, 3 patients within 3 weeks and 5 patients had not had blood tests done until 4 weeks after starting the medicines. A clinical review of each patient was completed and actions were taken to ensure patients received the appropriate monitoring.	

### Effective staffing

**The practice was not able to demonstrate that all 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.	Partial
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.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had a program of learning, however training records we reviewed showed that not all staff had completed the provider's relevant mandatory training. For example, there were gaps in training such as safeguarding, sepsis, GDPR, privacy and dignity and whistle blowing.</li> <li>• We found the clinical leadership team had no formal process in place to review and monitor the pharmacy dispensers working at the practice.</li> <li>• We found that staff appraisals had been completed and development opportunities were discussed with staff members as part of this process.</li> </ul>	

### Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Palliative care meetings were held every 2 months with the community teams. The practice had a care co-ordinator in place who organised the meetings and monitored the palliative care register. The care co-ordinator carried out home visits and did holistic checks of patients. Regular discussions were held where required with the district nursing team and the community matrons.</li> <li>• Systems were in place to share information about patients electronically with other services.</li> <li>• The practice shared relevant information with out of hours services to support continuity of care.</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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice offered health checks to new patients registering with the practice and NHS health checks to patients aged 40 to 74 years, which enabled them to identify any health risks and provide appropriate support and guidance to patients.</li> <li>• Practice staff encouraged patients to attend cancer screening programmes and vaccination programmes.</li> <li>• Practice staff were able to offer patients appointments with other services through the Primary Care Network (PCN), these included physiotherapy, social prescribing and a mental health practitioner to support their overall health and wellbeing.</li> </ul>	

### Consent to care and treatment

**The practice 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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Our clinical review of notes where a Recommended Summary Plan for Emergency Care and Treatment. (RESPECT) was coded as being in place, showed out of 4 records we viewed, only 1 document was on the patient record.</li> </ul>	

## Responsive

Rating: Good

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had received positive feedback from the GP National Patient Survey on access and through online reviews on how supportive the staff were and the care received.</li> <li>Extended access appointments were provided through the Primary Care Network (PCN). Each practice within the network was on a rota to provide this service. The extended access hours were from 6.30pm to 8pm Monday to Friday and 9am to 2pm on Saturday.</li> <li>The practice closed Thursday afternoon from 1pm. The phone lines were transferred to the PCN to answer calls from 1pm onwards and deal with patient enquiries.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am to 12.30pm 1.30pm to 6pm
Tuesday	8.30am to 12.30pm 1.30pm to 6pm
Wednesday	8.30am to 12.30pm 1.30pm to 6pm
Thursday	8.30am to 1pm
Friday	8.30am to 12.30pm 1.30pm to 6pm



Appointments available:	
Monday	8.30am - 5pm
Tuesday	8.30am - 5pm
Wednesday	8.30am - 5pm
Thursday	8.30am – 12.30pm
Friday	8.30am - 5pm

**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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families’ wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Two locum nurses were currently employed by the practice to provide additional nurse appointments for cervical screening and childhood immunisation.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

**Access to the service**

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Patients were able to access appointments face-to-face, by phone and through the practice website.</li> <li>• We saw from the appointment system that face-to-face and telephone consultations were available to book in advance with a named GP. On the day of inspection, we found there were 9 book on the day appointments still available for patients.</li> </ul>	

- Patients were able to request repeat medication by requesting this on the practice website, through email to the practice or through the NHS app.
- Patients with dementia, mental health and a learning disability were offered longer appointments.
- Appointments suitable for working patients were available at the practice and through arrangements with the primary care network (PCN) and extended services where appropriate.
- Interpreter services were available for patients who did not have English as their first language.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	67.5%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	78.2%	64.0%	54.4%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	72.8%	59.4%	52.8%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	85.8%	78.8%	72.0%	Tending towards variation (positive)

Source	Feedback
Interviews with patients	We spoke with 1 patient on the day of inspection. They told us they had no difficulties in getting an appointment and received regular follow ups. The patient told us they were happy with the services provided.

**Listening and learning from concerns and complaints**

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

<b>Complaints</b>	
Number of complaints received in the last year.	1
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

## Well-led

## Rating: Requires Improvement

We have rated the practice as requires improvement for providing well led services as governance processes required strengthening to ensure risks were identified, monitored and mitigated.

### Leadership capacity and capability

**There was compassionate and inclusive leadership at all levels, however this was not always effective.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice leadership team were aware of the challenges to maintain quality and sustainability; however, we found the managerial aspects of the practice needed strengthening to ensure staff in advanced leadership roles received the appropriate support.</li><li>• Staff members we spoke to told us that leaders were visible, and approachable, however communication was not always effective.</li><li>• We found staff working at the practice did not have the appropriate supervision to ensure they were carrying out the role they had been employed to do. For example: There was no clinical review in place for pharmacy dispensers or the clinical pharmacist.</li><li>• The leadership team had recently recruited a GP to support the clinical team and increase appointment availability.</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:	

- The practice had a set of core values that they worked towards. These were compassion, attention, respect and empathy. Feedback from patients through online comments showed staff were committed to providing a compassionate environment where patients were listened too.

**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.	Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff members we spoke to said they were able to speak to management to report any issues, if required.</li> <li>Feedback from staff during the inspection was that they felt positive about working at the practice.</li> <li>There was a whistleblowing policy and a duty of candour policy in place.</li> <li>We saw that whistleblowing and General Data Protection Regulation (GDPR) training were part of the mandatory training schedule, however not all staff were up to date with this training. For example: We found 5 staff had not completed whistleblowing training and 2 clinical staff had not completed GDPR.</li> </ul>	

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

Source	Feedback
Staff	We spoke with a range of staff during the inspection who told us they felt well supported and everyone worked together as a team.

**Governance arrangements**

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
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:	
<ul style="list-style-type: none"> <li>• Provider policies and procedures were available which were accessible to all staff. Discussions with staff showed they had an understanding and awareness of key policies such as safeguarding and whistleblowing. We looked at a sample of policies and saw they had been reviewed; however, we did find that some governance systems required strengthening further such as staff immunisation and mandatory training.</li> <li>• There were written standard operating procedures in place for the management of controlled drugs. However, these were not always followed.</li> <li>• There were some meeting schedules in place that were inclusive of all staff, however the leadership team told us that meetings were not always held as planned due to staff availability.</li> </ul>	

### Managing risks, issues and performance

**The practice did not have clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
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.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The leadership team had some assurance systems in place to monitor risk such as incidents and complaints, however this needed to be strengthened as the practice had failed to identify or risk assess several potential risks. For example, the clinical leadership team had no process in place to monitor the pharmacy dispensing staff, infection control and fire risk assessments had not been completed to identify any potential risks to both patients and staff.</li> <li>• The practice had systems in place for the actioning of safety alerts, however on reviewing the clinical system we found the process was ineffective and systems needed improvement to ensure all safety alerts were acted on.</li> <li>• The storage of controlled drugs in the dispensary was not in line with best practice guidance. We were unable to gain assurances that the cabinet used for these medicines was securely fixed.</li> <li>• Fridge temperatures for the dispensary fridge had not been recorded for months. The maximum and minimum temperatures were not always recorded correctly with the same temperature recorded for both.</li> <li>• We found there was no protected time allowed for the new clinical pharmacist to be provided with supervision and support on their consultations and prescribing by the clinical leadership team.</li> </ul>	

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness and busy periods, however staff told us that due to staff shortages it was difficult to find cover when required.
- There was a program of clinical auditing in place to monitor quality and implement improvements.

### 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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• We asked staff who worked in the dispensary about the NHS Controlled Drugs Accountable Officer. We were unable to gain assurances on who this was or where they would find this information. They were not aware this information was in the controlled drugs register.</li> <li>• The practice had completed a range of quality audits to monitor services and make improvements where identified.</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
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Staff told us that when staff consulted with patients remotely their identity was checked.</li> </ul>	

- Online consultations were held away from the main reception area to ensure confidentiality.
- Secure systems were used for patients to share information with the practice.

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Staff told us the practice was a small friendly family practice and there was an open door policy in place for staff to share ideas and concerns.</li> <li>• The practice was part of a primary care network which provided enhanced services to patients. These included physiotherapy, social prescriber and mental health practitioner.</li> <li>• The practice monitored patient feedback through the GP National Patient Survey and had recently commenced the NHS Friends and Family Test (FFT) in June 2023. The practice had received 670 responses to the FFT and 620 patients had rated the practice as very good/good.</li> <li>• The practice had a Patient Participation Group (PPG) currently with 4 members. There was a poster in the waiting room to encourage patients to join and a practice social networking site.</li> </ul>	

### Feedback from Patient Participation Group.

Feedback
We spoke with 1 member of the patient participation group who told us that there were currently 4 members in the group and the group met on average every 3 months. We were told that the group was kept well informed by the leadership team of any changes or new developments and had not received any negative feedback from patients on the services provided.

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	



- The practice had a mandatory training programme in place, however we found that this was not monitored effectively by the leadership team and identified gaps in staff training updates.
- The practice was a training practice for GP trainees, to provide them with support in their learning of general practice.
- The practice had a meeting schedule; however, we were told these were not always held due to staff availability.
- Significant events were discussed with staff during the year to share learning and mitigate further risk.

### 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)	$\leq -3$
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 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 those aged 25 to 49, and within 5.5 years for those 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.