

Care Quality Commission

Inspection Evidence Table

Drs Sidhu & Batra (1-583013867)

Inspection date: 12 September

Date of data download: 23 August 2022

Overall rating: Requires Improvement

We rated the practice as requires improvement overall because systems and processes were not always implemented. The systems in place for good governance and management were not always effective.

Safe

Rating: Requires Improvement

We rated the practice as requires improvement for providing safe services because:

- Processes for medicines reviews and medicines management were not always followed.
- The practice were an outlier for some prescribing indicators.
- There was no documented risk assessment in place to mitigate risks relating to emergency medicines not held by the practice.
- Safety alerts had not all been responded to.

Safety systems and processes

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

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

Safeguarding	Y/N/Partial
The designated safeguarding lead was supported by the business manager who was the administration safeguarding lead. Staff were aware of who to go to if they needed to raise any concerns. There were safeguarding policies in place for children and vulnerable adults.	
Alerts were used on patient records to identify safeguarding concerns.	
There were local authority contact details available in consultation and treatment rooms.	

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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: April 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: February 2022 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: The practice had two members of staff identified as fire marshalls and had carried out a fire drill in May 2022. The evacuation procedure and fire assembly points were displayed on the walls in the practice.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: August 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: The practice had a dedicated infection prevention and control (IPC) lead. Additional IPC measures had been put in place during the COVID-19 pandemic. For example, <ul style="list-style-type: none"> • Personal protective equipment was used by all staff. Patients and visitors were requested to wear face coverings in the building. 	

- Hand-gel was available for staff, visitors and patients throughout the building including at the entrance and exit.
- All staff were responsible for cleaning the surfaces of their work area after face to face appointments with patients.
- COVID tests were available for staff to use if they displayed symptoms.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<p>Explanation of any answers and additional evidence:</p> <p>Reception and administrative staff had been trained to identify red flag symptoms that required immediate attention.</p> <p>The practice had plans to move to a new building and were aware this would attract new patients. They had planned to recruit more GPs and support staff to meet the increased demand.</p>	

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 medicines, including medicines optimisation. However, they were not always implemented.

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.09	0.83	0.79	Tending towards variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	11.1%	9.6%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	6.96	5.17	5.29	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	194.9‰	122.3‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	2.55	0.72	0.60	Significant Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	12.2‰	8.3‰	6.8‰	Tending towards variation (negative)

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

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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The practice worked with the Integrated Care Board (ICB) medicines team to monitor and make improvements with prescribing. There had been a steady reduction in the prescribing of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) over the past 12 months.</p> <p>Processes were in place for structured medicines reviews for patients on repeat medicines. We reviewed the clinical records for patients prescribed a potassium sparing diuretic. There were 55 patients prescribed this medicine with 34 flagged as requiring monitoring. We reviewed a sample of 5 patient records and found 3 patients had not had a renal function test in the previous 6 months. During the inspection, the practice informed us that they had looked at the records and put plans in place to invite patients for a review.</p> <p>We reviewed a sample of patient records for those prescribed methotrexate, a high-risk medicine, that required additional monitoring of patients' health. We found the practice had a shared care agreement</p>	

Medicines management	Y/N/Partial
with the secondary care provider and they followed the shared care guidelines. However, blood test results completed by the secondary care provider were not always added to the patient record by the practice.	
The practice did not hold a supply of benzylpenicillin used to treat suspected meningococcal infection or atropine used to treat a low pulse rate that can occur during the fitting of contraceptive coils or minor surgery. There was no documented risk assessment in place to demonstrate whether risks had been mitigated. During the inspection, the practice provided evidence that they had considered the need for these medicines and ordered a supply straight away.	

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: The practice had a process in place for reporting significant events. An electronic reporting form was available on the practice computer system for all staff to access. A log of all significant events was kept to help identify trends. Learning from significant events was shared during practice meetings.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Paperwork containing patient information was found in the practice staff kitchen.	Affected patients were contacted and informed of the incident and an apology was issued. A new system for storing paperwork relating to patients was implemented with storage trays put in the reception office. There was an all staff briefing to remind staff to store patient identifiable information securely. All staff have received information governance training.
The equipment on the emergency trolley was not kept in order which made it difficult to access when treating a patient.	The emergency equipment was reviewed and stored in an appropriate way. Regular checks were undertaken to ensure the equipment was maintained and ready for use.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Safety alerts were received by the business manager who shared them with the appropriate clinicians. A log was kept of safety alerts and actions taken.</p> <p>The provider was unable to demonstrate that all relevant safety alerts had been responded to. For example, a review of the patient record system identified 31 patients prescribed a combination of a medicine used to treat those who have had a stroke to reduce their chances of having a further one, and a medicine used to reduce stomach acid. A safety alert issued in 2014, advised that these medicines should not be prescribed together as the medicine used to reduce the chance of having a stroke was made less effective. We reviewed a sample of 5 of these patients and found there was no evidence documented that the patients had been informed of the risk.</p> <p>During the inspection, we were informed that all of these patients had been contacted for a review.</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. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: The practice had systems in place to keep all clinical staff up to date. Staff had access to clinical templates and National Institute for Health and Care Excellence (NICE) best practice guidelines. They used this information to deliver care and treatment that met patients' needs.	

Effective care for the practice population

Findings
<ul style="list-style-type: none">• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.• Health checks, including frailty assessments, were offered to patients over 75 years of age.• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.• The practice had 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- A remote review of the patient record system showed that patients generally had received appropriate long-term condition reviews and the practice had followed up patients who had received treatment in hospital or through the out of hours service.
- Patients diagnosed with asthma who had been prescribed 2 or more courses of rescue steroids had received an appropriate review. However, the patient records did not always indicate they had been issued with a steroid card.
- Patients diagnosed with hypothyroidism had not all received appropriate monitoring. For example, 87 patients out of 353 diagnosed with hypothyroidism were overdue a blood test. We reviewed a sample of 5 patient records and found the practice had started to invite these patients for a review.
- There was evidence from the remote clinical searches that patients diagnosed with chronic kidney disease were referred to secondary care appropriately. The practice did not always download the blood test results for patients who received monitoring in secondary care.
- There was evidence from the remote clinical searches that patients diagnosed with diabetes had an annual review throughout the COVID-19 pandemic.
- The practice had recruited a clinical scientist who was responsible for the identifying patients who required monitoring or a review of their condition.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	83	85	97.6%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	63	65	96.9%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	63	65	96.9%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	63	65	96.9%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	72	75	96.0%	Met 95% WHO based target

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

Any additional evidence or comments
The practice contacted the parents of guardians of children not brought for their immunisation appointments by telephone and sent reminders of appointments. The practice nurses provided education of the importance of childhood immunisations to parents or guardians as needed.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to	68.4%	N/A	80% Target	Below 70% uptake

64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.9%	55.6%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	59.9%	60.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	47.4%	57.0%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments

The practice were aware they were below the 80% target set by the UK Health and Security Agency for the uptake of cervical screening.

There were alerts on the patient records that indicated if they were overdue cervical screening. We were informed that all clinical staff opportunistically offered cervical screening to eligible patients when they attended the practice.

Text message invites were sent to eligible patients and these contained links to health information on the benefits of cervical screening.

Extended access appointments were available for eligible patients to attend in the evening or weekend for cervical screening.

Monitoring care and treatment

The practice had a programme of quality improvement activity and had started to review 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

Any additional evidence or comments

The practice had a programme of clinical audits in place that included areas of prescribing and actions from safety alerts. Outcomes of audits were shared and discussed at clinical meetings.

For example,

- An audit had been undertaken to ensure patients diagnosed with atrial fibrillation received appropriate treatment to reduce the risk of developing blood clots. The audit identified which patients were prescribed recommended treatments and those patients who were not in receipt of medication were invited to the practice for a review of their condition and treatment.
- An audit had been undertaken to ensure patients diagnosed with diabetes were on the correct treatment according to their blood test results and those whose results had gone out of range during the COVID-19 pandemic were suitably monitored. The audit showed the patients received a regular review of their condition and prescribed medicines.

The practice had recruited a clinical scientist who was responsible for carrying out clinical audits and searches of the patient record system to ensure patients were reviewed and monitored according to current guidelines. Second cycle audits were scheduled to demonstrate whether improvements made had a positive impact..

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
<p>Explanation of any answers and additional evidence:</p> <p>Staff had protected time for learning and had access to online training.</p> <p>Staff were supported with annual appraisals and informal one-to-one discussions as required. All staff had received an appraisal in the previous 12 months.</p> <p>Staff who wished to develop were offered opportunities to undertake additional training. For example, a health care assistant was supported to undertake nurse associate training.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had regular meetings, every three months, with community staff to discuss patients with complex needs or those who were receiving palliative care.</p>	

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> <p>The practice had access to a social prescriber through the primary care network who they could refer patients to for extra support.</p> <p>There were links to health information advice on the practice website.</p> <p>The practice had a care-coordinator who carried out wellness and wellbeing checks for housebound patients and those who contacted the practice frequently.</p>	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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

Responsive

Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	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> <p>The practice informed us they made use of telephone and online consultations to support patients during the COVID-19 pandemic.</p> <p>They remained open for patients that required a face-to-face appointments. All patients received a telephone triage then a face-to-face appointment was offered if required.</p> <p>Patients could book appointments by telephone, in person or via online services.</p> <p>Reception staff have received training to ensure the most appropriate appointments are booked.</p> <p>There were some appointments reserved for patients who had contacted the NHS 111 service and were advised they needed to contact a GP.</p> <p>The business manager had carried out a review of the appointment system which identified additional GP and practice nurse appointments were required to meet patient demand.</p>	

Well-led

Rating: Requires Improvement

We rated the practice as requires improvement for providing well-led service because:

- The systems in place for good governance and management were not always effective.
- The practice did not have clear and effective processes for managing risks, issues and performance.

Leadership capacity and capability

There was compassionate, inclusive 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 were aware they had an increasing patient population which had an impact on appointment availability. They had plans to recruit more staff and used long-term locum staff to meet demand. The business manager had been recruited to the role within the previous 12 months and had training and development plans in place.	

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 mission statement in place that identified their aims and vision for patients and staff. This was available on the practice website. The practice had a strategy and business plan in place. This included a move to a new purpose-built building within the near future. They had planned to develop their service and provide space for community, mental health and pharmacy services to work from the same building. The practice was also working towards becoming a training practice.	

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
<p>Explanation of any answers and additional evidence:</p> <p>Staff were offered independent, confidential support through an employee assistance programme provided by an external company.</p> <p>A member of the management team had been identified as the Freedom to Speak Up Guardian. Following discussions during the inspection, an external person was also identified, from a neighbouring practice, for staff to approach. This was documented in the practice whistleblowing policy.</p>	

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

Source	Feedback
Staff	Feedback from staff through discussions and feedback forms was positive. Staff reported that the practice was a good place to work and they were supported by the GP partners and managers. They reported their views were listened to and acted upon. Staff said there was good communication and teamwork within the practice.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, they were not always effective.

	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
Explanation of any answers and additional evidence:	

The practice used policies and procedures to govern their work. However, there was a lack of oversight to ensure policies and procedures regarding medicines management and effective management of patients was applied.
All staff had a job description and an employment contract.

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.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>Processes for medicines reviews were not always followed. The provider was unable to demonstrate effective clinical oversight to ensure all relevant safety alerts had been responded to. Following the inspection, we were informed a clinical pharmacist from the primary care network was working with the practice to complete medicine reviews.</p> <p>The practice had completed single cycle audits. They had recruited a clinical scientist to undertake audit and monitor quality improvements. At the time of the inspection they were new to their role and second cycle audits had not been completed.</p> <p>The practice had not carried out a risk assessment for the emergency medicines not held. During the inspection the practice ordered a supply of the medicines to stock.</p> <p>The practice had a business continuity plan in place that had been updated following the COVID-19 pandemic to include actions to take in future in the event of another pandemic.</p> <p>The practice scheduled to update the plan again when they moved to their new premises.</p>	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y

There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice implemented a series of changes to ensure patients were able to access care and treatment during the COVID-19 pandemic.</p> <p>There was an increased use of telephone and video consultations during the COVID-19 pandemic. We were informed that patients were all offered an initial triage appointment via the telephone with a clinician to see if a face-to-face appointment was necessary.</p> <p>Risk assessments of the building were made, and changes implemented to ensure the safety of patients and staff.</p> <p>Personal COVID-19 risk assessments were completed by staff.</p> <p>Personal protective equipment was available.</p>	

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

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y

The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group (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
Explanation of any answers and additional evidence: The practice had a feedback box in the patient waiting area for patients to leave comments on the service. There was a PPG that met 4 times a year. The practice had also formed a virtual PPG for patients who did not attend meetings. The PPG discussed patient feedback from sources such as the national patient survey and practice issues and patient experience to help improve the service.	

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
Explanation of any answers and additional evidence: The practice had protected time for learning. They made use of significant event analysis and complaints to learn and make improvements.	

Examples of continuous learning and improvement

The practice was working to become a training practice in the future.
There had been a recent focus on preparing to move premises.

GP partners took lead roles within the primary care network and the integrated care board to provide additional services to the community. For example, extended access appointments and the prescription ordering service.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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