

# Care Quality Commission

## Inspection Evidence Table

### Castlegate & Derwent Surgery (1-541053555)

Inspection date: 17 – 20 April 2023

Date of data download: 13 April 2023

## Overall rating: Requires Improvement

We have rated the provider requires improvement because:

- Due to the practice not currently offering patients NHS electronic prescribing (ePS) or repeat dispensing (eRD) services, an additional step of 'logging out' prescriptions collected by external pharmacies increased the time taken to process repeat prescriptions. As part of our inspection we spoke with 9 patients, 6 told us about issues with their prescriptions.
- There were significant gaps in mandatory training for clinical members of staff.
- The practice could not fully assure the competencies of non-medical prescribers
- We were not assured that learning from significant events had been maximised.
- We could not be assured that learning from complaints was maximised.
- There was not a clear governance structure which meant systems were not constantly appropriately monitored.
- The practice did not have comprehensive assurance systems which were regularly reviewed.

# Safe

## Rating: Requires Improvement

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

- There were significant gaps in mandatory training for clinical members of staff.
- The practice could not fully assure the competencies of non-medical providers.
- We were not assured that learning from significant events had been maximised.

### Safety systems and processes

**The practice did not have 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.	N
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Although we found that staff engaged and understood local safeguarding policies, 2 out of 4 Advanced Nurse Practitioners (ANPs) had not completed their mandatory training on safeguarding adults and 1 had not completed safeguarding children training prior to our site visit. By the time of our site visit all ANPs were up to date with safeguarding training. We found that 3 out of 4 treatment nurses child safeguarding training had lapsed. One GP had also not completed safeguarding training for both adult and children. We found that across clinical members of staff there were significant gaps across many aspects of mandatory training.</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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• We reviewed 3 recruitment files and found that appropriate recruitment checks had been carried out.</li></ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14/04/2023	Partial
There was a fire procedure.	Y
Date of fire risk assessment: 05/08/2022 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We found that a recent health and safety risk assessment had been completed however there were actions that the practice needed to take. An action plan was provided with timescales for when actions would be completed.</li> </ul>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met however not all staff had received the required training.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: March 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We found the practice to be in a good state of cleanliness and staff understood the importance of infection prevention and control. However we found gaps in mandatory training on infection prevention and control across clinical members of staff. This included 4 out of 10 GPs, 2 out of 4 ANPs and 3 out of 4 treatment nurses.</li> <li>The practice had recently recruited a new lead nurse who would be the lead for infection prevention and control and were waiting for them to be able to complete their training so that an up to date infection prevention and control audit could be completed.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y

There were enough staff to provide appointments and prevent staff from working excessive hours	Y
--	---

## 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. <sup>1</sup>	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.</li> </ul>	

## Appropriate and safe use of medicines

### The practice had 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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	0.67	0.94	0.82	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). (01/10/2021 to 30/09/2022) (NHSBSA)	6.6%	8.3%	8.5%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
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 (01/04/2022 to 30/09/2022) (NHSBSA)	4.47	4.61	5.28	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	106.0‰	171.0‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.12	0.28	0.58	Significant Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	4.4‰	7.2‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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 high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y

Medicines management	Y/N/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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li>• We found that the practice did not have thorough systems in place to assure the competencies of non-medical prescribers. There was no auditing process to check competencies of staff. We did find that non-medical prescribers had regular access to speak with GP's informally to seek clinical supervision.</li> <li>• Our clinical searches identified that 899 patients had had a medicine review in the last 3 months. We looked at 5 patients records, and all 5 that we looked at demonstrated medicine reviews were thorough and clearly documented. There was indication that medicine reviews had been conducted involving patient or carers.</li> <li>• Clinical searches highlighted 125 patients prescribed methotrexate (which is used to treat inflammatory conditions, including rheumatoid arthritis). In total 9 patients had not had the required monitoring. We looked at 5 patient records and 4 of these patients were identified as not having the required monitoring. The practice provided us with an action plan showing a new stronger process to demonstrate how monitoring would be improved. The practice were using this as a quality improvement process.</li> <li>• Clinical searches highlighted 269 patients potentially having a missed diagnosis of chronic kidney disease (CKD) 3 – 5. We looked in detail at 5 patient records which showed that 4 of these 5 patients had a missed diagnosis of CKD. The practice immediately started reviewing these patients and provided an action plan. A new search function was added to the clinical system to allow the practice to more easily see which patients were at risk of CKD so that they could be monitored more effectively.</li> <li>• We also ran a clinical search which identified 95 patients out of 192 prescribed gabapentinoids (medicine used to treat epilepsy and nerve pain) had not had a review in the last 12 months. We looked in detail at 5 patient records, 1 of the 5 patients was overdue a medicine review and, 1 of the 5 patients had not been told about the risks associated with this medicine for women of childbearing age.</li> <li>• The practice had controlled drugs on site, they had processes in place to manage stock levels, safely store medicine and dispose of medicine when required.</li> </ul>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	N/A
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.	N/A

Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	N/A
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.	N/A
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/A
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.	N/A
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.	N/A
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> <li>Services to dispensing doctor patients were provided by the affiliated GPhC (General Pharmaceutical Council) registered pharmacy under an SLA (service level agreement) with the practice. This meant that for example, dispensing and staff training was overseen by a GPhC (General Pharmaceutical Council) registered pharmacist on a day-to-day- basis. Inspection reports for the GPhC Registered Pharmacy are available on their <a href="#">website</a>.</li> <li>We looked at how the practice was monitoring compliance with the pharmacy SLA. Records of staff qualifications, dispensing error and near miss logs, and complaints were maintained and kept under regular review. Incidents and near misses were discussed at staff meetings for learning.</li> <li>Following our inspection, the practice took action to separate audit and assurance monitoring of the service level agreement for services provided to dispensing doctor patients, from the pharmacy governance and assurance processes.</li> </ul>	

## Track record on safety and lessons learned and improvements made

**The practice had a system to learn and make improvements when things went wrong, however we did not have assurances that learning was fully maximised**

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.	N
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.	N
Number of events recorded in last 12 months:	7
Number of events that required action:	7
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice told us that they were undertaking work to improve how significant events were identified, reported and how learning was obtained. Although staff knew how to report incidents, we found that some events were discussed informally rather than officially recorded and investigated.</li> <li>We saw evidence that two similar incidents had taken place a couple of months apart. We were not assured that learning had been gained and shared following the first incident as the event was repeated in the second incident.</li> </ul>	

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

Event	Specific action taken
A patient who was already being prescribed a long term medicine was prescribed another medicine without a recommended blood test being carried out.	A warning alert was added to the clinical system for all INR patients so that this would not be missed for future patients who required the same treatment.
A referral for was not written after a discussion with a patient. This was then not picked up on the clinical system when running a missed referral search.	The clinical system only picks up missed referrals when there is a template form from the consultation. Awareness was given to clinicians to be aware of their own workload and use the task system as a reminder. Following this the practice is running searches twice a week to audit the referral process.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Although there was a system in place for recording and acting on safety alerts, we found that not all patients had received the required monitoring following a safety alert. Our clinical searches found that 15 patients out of 68 on mirabegron had not received an annual blood pressure check. Mirabegron is medicine used to treat an overactive bladder, following a medicines and healthcare products regulatory agency alert (MHRA) patients are required to have their blood pressure taken annually. We looked at 5 patient records, 3 of these 5 patients were overdue their annual blood pressure monitoring.</li> </ul>	



## 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. <sup>1</sup>	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	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 prioritised care for their most clinically vulnerable patients.	Y

### Effective care for the practice population

Findings
<ul style="list-style-type: none"><li>• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.</li><li>• Those identified received a full assessment of their physical, mental and social needs.</li><li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li><li>• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li><li>• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li><li>• Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.</li><li>• All patients with a learning disability were offered an annual health check.</li></ul>

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice 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 identified that they had patients in hard to reach areas. Due to the location of the practice many patients worked as farmers on in the agricultural industry. The practice found that lots of these patients were unwilling to attend the practice. As a result of this they developed the “Agri health matters” initiative. They attended regular agricultural shows where patients are given health checks in a convenient location for them which improved their health monitoring.

## Management of people with long term conditions

### Findings

- We found evidence that patients with long-term conditions did not have a fully effective annual review to check their health and medicines needs were being met. Our clinical searches identified 82 patients with asthma who had been prescribed 2 or more courses of rescue steroids. We looked in detail at 5 patients records, there was no evidence of follow up appointments for these 5 patients.
- 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 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.
- Our clinical searches identified 17 patients with CKD 4 and 5 who had not had the required monitoring in the last 9 months. We looked at 5 patient records, all 5 of these patients had received the required monitoring.
- Clinical searches identified 43 patients out of 1070 with diabetic retinopathy who's latest HbA1c was above 74. We looked at 5 patient records, all 5 of these patients were due medicine reviews. The practice then implemented a new search on their clinical system to be able to identify these patients more thoroughly.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of	100	104	96.2%	Met 95% WHO based target

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)				
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)	121	127	95.3%	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)	122	127	96.1%	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)	121	127	95.3%	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)	146	147	99.3%	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 average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	80.1%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	66.7%	65.4%	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)	73.9%	70.3%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	55.7%	53.5%	54.9%	No statistical variation

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.

## Monitoring care and treatment

**The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

<p>The practice completed a retrospective audit looking at the missed referrals over the last year. This audit identified 54 missed referrals out of 4790 referrals that needed to be made. Following this audit learning was achieved to reduce this number further by having a new task prompt on their clinical system on completion of the referral form to reduce missed referrals.</p> <p>The practice also completed quality improvement audits in:</p> <ul style="list-style-type: none"> <li>Methotrexate monitoring</li> <li>Aspirin and secondary prevention of myocardial infarction</li> <li>Primary hypothyroidism</li> </ul>
---

Gabapentin and pregabalin  
Proton pump inhibitors

## 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.	N
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Although we found the practice had a programme of learning and development, we found gaps in the timely completion of expected training.</li> <li>The practice had an induction programme for all members of staff. Staff worked through this induction with support from managers and colleagues until they were deemed competent.</li> <li>Feedback from CQC staff questionnaires highlighted that members of staff had access to regular appraisals.</li> </ul>	

## 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

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Y

## Caring

**Rating: Good**

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	87.0%	85.8%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	79.2%	85.4%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	95.9%	94.4%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	75.7%	74.0%	72.4%	No statistical variation

Question	Y/N
----------	-----



The practice carries out its own patient survey/patient feedback exercises.	Y
---	---

#### Any additional evidence

- The practice gathers its own feedback in a number of different ways. They gather information through the friends and family test. Information was recorded and broken down into positive, neutral, and negative so further learning can be acquired.
- They also gathered feedback from their social media page and NHS choices.

## Involvement in decisions about care and treatment

### Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Easy read and pictorial materials were available.</li> </ul>	

Source	Feedback
Interviews with patients.	As part of our inspection process, we spoke with patients at the practice to gather their feedback. In total we spoke with 9 patients, 8 of whom told us positive feedback and praised staff attitudes as “respectful” and “felt they were listened to”.  All the patients we spoke to, told us that they felt they had enough time during consultations and that their privacy and dignity was maintained.

## 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 average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	90.8%	91.8%	89.9%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	386 patients were registered as carers, this worked out at 2% of the practice population.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>We found that the practice regularly reviewed their carers register to ensure carers and cared for patients had received the correct immunisations and vaccinations.</li> <li>The practice had good working relationships with local support groups and facilitated drop-in sessions for carers monthly.</li> <li>The practice were able to signpost patients to social prescribers when required.</li> <li>We found that the practice had a “carers corner” with information available for cared for patients and carers.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>The practice had meetings every morning to discuss and review deaths of patients. This ensured that the right clinician were aware of a patient’s death and would contact recently bereaved patients.</li> <li>A bereavement card was sent to relatives.</li> <li>The practice was in the process of setting up a local bereavement group using volunteers which would be hosted at the practice.</li> </ul>

## Privacy and dignity

### The practice respected patients’ privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>A confidential meeting room was available for patients when required.</li> </ul>	

## Responsive

## Rating: Requires Improvement

We have rated the practice as requires improvement for providing a responsive service because:

- Due to the practice not currently offering patients NHS electronic prescribing (ePS) or repeat dispensing (eRD) services, an additional step of 'logging out' prescriptions collected by external pharmacies increased the time taken to process repeat prescriptions.
- We could not be assured that learning from complaints was maximised.

### Responding to and meeting people's needs

#### Services did not always meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	N
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	N
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 access to an interpreter service when needed if the patients first language was not English.</li> <li>• Patients could order their prescriptions in person, by telephone or electronically. The prescription team provided additional support to patients who may find it difficult to order their medicines.</li> <li>• The practice did not currently offer patients NHS electronic prescribing (ePS) or repeat dispensing (eRD) services. This meant that patients or their nominated representative had to order and collect paper prescriptions from the practice for their medicine to be dispensed. Similarly, potentially suitable patients were not able to benefit from eRD, which makes it quicker and simpler for them to manage their repeat medicines. One patient had been incorrectly advised that 'NHS England prevented dispensing practices from using electronic prescribing'.</li> <li>• In the absence of ePS, individual arrangements were made to post prescriptions to a patient who did not use a pharmacy local to the practice. The prescription team described how 1 patient temporarily registered with another practice, so they didn't need to collect their paper prescription while they were away staying with family.</li> <li>• Patients were advised that prescriptions would be ready to collect after 72 hours (excluding weekends and holidays). An additional step of 'logging out' prescriptions collected by external pharmacies increased the time taken to process repeat prescriptions.</li> <li>• We gathered patient feedback as part of our inspection. Six out of 9 patients we spoke to told us about issues they had had when either ordering or collecting prescriptions. Three patients reported waiting too long for their prescription to be sent to a local community pharmacy. Two patients spoke of issues when getting a prescription from the dispensary located within the practice and 1 patient told us they avoided the dispensary altogether because of previous issues.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 – 18:30
Tuesday	08:00 – 18:30
Wednesday	08:00 – 18:30
Thursday	08:00 – 18:30
Friday	08:00 – 18:30
Appointments available:	
Monday	08:00 – 18:30
Tuesday	08:00 – 18:30
Wednesday	08:00 – 18:30
Thursday	08:00 – 18:30
Friday	08:00 – 18:30

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>• Patients had a named GP who supported them in whatever setting they lived.</li> <li>• 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.</li> <li>• There was a medicines delivery service for housebound patients.</li> <li>• The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. The practice also offered appointments through the extended access scheme. Extended access is the offer, to registered patients of a practice, of pre-bookable appointments outside of core contractual hours, either in the early morning, evening or at weekends.</li> <li>• All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.</li> <li>• The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.</li> <li>• People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.</li> </ul>

## 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 minimize the length of time people waited for care, treatment or advice	Partial
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 advised that prescriptions would be ready to collect after 72 hours (excluding weekends and holidays). An additional step of 'logging out' prescriptions collected by external pharmacies increased the time taken to process repeat prescriptions. Six out of 9 patients we spoke to told us about issues they had had when either ordering or collecting prescriptions.</li> <li>• The practice offered a range of different appointments for patients, these included face to face, telephone and video consultations.</li> <li>• The practice also offered appointments through the extended access scheme. Extended access is the offer, to registered patients of a practice, of pre-bookable appointments outside of core contractual hours, either in the early morning, evening or at weekends.</li> <li>• Extended access appointments were available with a wide range of clinical staff.</li> </ul>	

## 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 average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	65.8%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	63.1%	57.1%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	52.5%	55.0%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	77.4%	76.8%	71.9%	No statistical variation

Source	Feedback
NHS Choices	Over the past 12 months the practice had received 28 5-star reviews. There was particular praise for staff attitudes over how patients were treated. The practice received 2 1-star reviews, however with both of these reviews they tried to engage with the patients so that improvements could be made.

## Listening and learning from concerns and complaints

**Complaints were listened and responded to however we could not be assured that they were used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	37
Number of complaints we examined.	37
Number of complaints we examined that were satisfactorily handled in a timely way.	37
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

	Y/N/Partial
--	-------------



Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Although we found that complaints were investigated and handled in a timely way, we did not have complete assurances that learning was always achieved following a complaint. We found that over the last year there was a theme of complaints made around delays for prescriptions. We did not find evidence to show that the process had been improved. This was further evidenced when speaking with patients, 6 out of 9 patients we spoke with told us about issues they had faced due to delays for prescriptions.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A 2 week wait referral was not booked properly for a patient.	Staff training was undertaken and new policies and procedures were implemented to ensure 2 week wait referral appointments were booked correctly.
A patient's referral to the musculoskeletal (MSK) team was delayed. The patient had to ring 4 times to chase up this referral.	The practice implemented a new system to confirm receipt of referrals to the MSK service. Referrals are not actioned as complete until the surgery has received confirmation of receipt of the referral. Apologies were given to the patient and asked if this could be used as a learning tool by the referrals team.

## Well-led

## Rating: Requires Improvement

- There was not a clear governance structure which meant systems were not constantly reviewed
- The practice did not have a comprehensive assurance systems which were regularly reviewed.
- We could not be assured that systems were in place to hold managers and leaders to account.

### Leadership capacity and capability

**There was compassionate, inclusive leadership at all levels. We did not have full assurance that leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	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.	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>• Although the practice had identified challenges to quality and sustainability, we could not be assured that their current governance systems in place were robust as they had been recently implemented. We found that the practice had been through a recent management change and due to this not all systems and processes were fully embedded yet. After the inspection the provider wrote to us and shared with us a list of improvement activities that had been initiated and shared with all staff.</li></ul>	

### Vision and strategy

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

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

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff feedback received highlighted that staff felt comfortable to raise concerns. Staff were also able to identify who the practice's Freedom to Speak Up Guardian was.</li> </ul>	

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

Source	Feedback
CQC completed electronic staff questionnaires	The majority of responses to the staff questionnaires we received described the practice as a "friendly" and "good" place to work. None of the questionnaires received had any negative comments about the culture of the organisation.

## Governance arrangements

### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
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>Due to a sudden change in management at the practice we found that governance of the practice was lacking. We found there were gaps in mandatory training including safeguarding and infection prevention and control for clinical staff. After the inspection the provider wrote to us and shared with us a list of improvement activities that had been initiated and shared with all staff.</li> <li>A recent infection prevention and control audit had not taken place. A recent health and safety risk assessment had been completed, there were outstanding actions that had not been completed in a timely manner.</li> </ul>	

- Managers at the practice did not have access to all the required policies and procedures. After the inspection we were given new service level agreements.

## 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.	N
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Since the recent change of management at the practice assurance processes had yet to be embedded. Therefore the practice was unable to provide full assurance they were being regularly reviewed and improved.</li> <li>Due to the managerial change we found that managers and leaders of the practice did not have access to all the relevant policies and procedures. As a result of this the practice provided us with new policies and service level agreements which had been created following the inspection.</li> </ul>	

## Appropriate and accurate information

**The practice did not always act on appropriate and accurate information.**

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had identified the way in which it had previously held senior leaders to account was insufficient and had led to issues with the way the practice operated and served its patients. We saw evidence the senior team had begun to review this and were implementing new systems to scrutinise staff and senior leaders performance.</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

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had an active Patient Participation Group (PPG) following engagement from the practice's administration lead. Through their work they were able to effectively communicate with the group and inform them about new services that were available.</li> <li>The practice also used the PPG to engage with other patients to explain processes that happened at the practice to improve their understanding.</li> </ul>	

### Feedback from Patient Participation Group.

Feedback
We spoke with 4 members of the PPG, they told us: <ul style="list-style-type: none"> <li>They had a good working relationship with staff</li> </ul>

- The practice engaged with them to hold roadshows at various locations in the local area to receive more feedback from the community and raise awareness of the best ways to interact with surgery staff.
- Members of the PPG attended the surgery at 8am to observe how reception and the appointment system operated. Members of the group were able to see how busy it was and how many calls needed answering. It also enabled them to understand the complexity of the appointment systems and how not every nurse appointment or healthcare appointment may be suitable for the appointment needed by the patient. This learning was then cascaded to the wider patient group.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

## Examples of continuous learning and improvement

The practice identified that they had patients in hard to reach areas. Due to the location of the practice many patients worked as farmers on in the agricultural industry. The practice found that lots of these patients were unwilling to attend the practice. As a result of this they developed the “Agri health matters” initiative. They attended regular agricultural shows where patients are given health checks in a convenient location for them which improved their health monitoring.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a SICBL 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 SICBL 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.