

# Care Quality Commission

## Inspection Evidence Table

### Glyndon PMS (1-542519665)

Inspection date: 25 and 26 August 2021

Date of data download: 19 August 2021

## Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

## Safe

## Rating: Good

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial <sup>1</sup>
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial <sup>2</sup>
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y <sup>3</sup>
Staff who acted as chaperones were trained for their role.	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
1. Two out of six staff were not trained to the appropriate safeguarding children level for their role. Following the inspection, the provider forwarded evidence that the staff had undertaken the proper training.	
2. The practice did not maintain a child safeguarding register; however, they did maintain a child protection register. Children were coded and could be located if a search was carried out. The practice had a safeguarding register with 28 patients; three were reviewed in the last year.	

Safeguarding	Y/N/Partial
3. We reviewed the recruitment files of six members of staff. All had received a DBS check.	

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 Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: In the main, staff vaccinations were monitored appropriately. However, one member of the clinical staff team did not have an updated vaccination status in their recruitment file.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: September 2021	Y
There was a record of equipment calibration. Date of last calibration: 07/09/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N/A
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 4 September 2020 Extinguishers: 4 September 2020.	Y
Actions from fire risk assessment were identified and completed.	N/A
Explanation of any answers and additional evidence:	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 02/09/2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 02/09/2021	Y
The practice did not have a premise/security or health and safety risk assessment at the time of the inspection. Following the inspection, the practice forwarded the completed documents. Legionella risk assessment: 19/09/2020	

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Y
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: October 2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

## 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

## 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 <sub>1</sub>

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
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We checked the practice's global in-tray for blood test results and found 148 results; the oldest was dated 9 September 2021. We discussed this with the provider, who said they had been actioned but not removed from the list.

### Appropriate and safe use of medicines

## The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.47	0.54	0.70	Variation (positive)
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). (01/04/2020 to 31/03/2021) (NHSBSA)	10.9%	10.3%	10.2%	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 (01/10/2020 to 31/03/2021) (NHSBSA)	5.73	5.64	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	90.1‰	72.9‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.75	0.44	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	8.6‰	4.7‰	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

Medicines management	Y/N/Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial <sub>1</sub>
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 <sub>1</sub>
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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 <sub>2</sub>
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial <sub>2</sub>
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>1. A hospital carried out the majority of drug monitoring results viewed during the inspection. We found one patient who was prescribed a high-risk drugs without the appropriate blood monitoring test result being recorded. In response to the draft report, the provider told us patients were not coded as pre-diabetic for insurance purposes, and they had a blood test every three to four months for monitoring purposes. Nevertheless, the prescriber's responsibility is to ensure that a risk assessment is completed for all patients considered to be at risk and coded, as per current NICE guidance.</p> <p>2. Since 2016, the practice has not maintained the complete list of recommended emergency medicines. The practice also chose not to have an Automated External Defibrillator (AED) on the premises. A risk assessment was carried out, stating the provider's rationale for their decision not to</p>	

Medicines management	Y/N/Partial
<p>stock all the recommended emergency medicines and not to stock an AED. Their reasons are listed below:</p> <ul style="list-style-type: none"> <li>• A pharmacy is in close proximity to both sites</li> <li>• Emergency services are available if required</li> <li>• Hospital services within two miles distance from the practice</li> </ul> <p>The practice had an oxygen cylinder which was regularly checked to ensure it was fit for use. All the medicines held at the practice were in date and checked regularly.</p>	

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

**Although the practice had a system in place to record safety incidents there was no evidence that incidents would be used to learn and make improvements.**

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.	Partial
There was a system for recording and acting on significant events.	Partial
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:	0
Number of events that required action:	N/A
<p>Staff were aware of what constituted a safety incident or near misses; however, not all incidents were recorded. Not all staff knew there was an incident book at reception for recording incidents. All staff said they would inform the practice manager if an incident occurred. The provider told us that all staff were told where to find the incident book after the inspection.</p> <p>The provider had not identified any safety incidents or near misses in the last two years. The practice staff meeting minutes did not have a section to discuss incidents or learning routinely.</p>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>We identified four patients whose records did not show evidence of being informed of the potential risks associated with the combination of drugs they prescribed.</p> <p>We saw examples of actions taken on recent alerts, for instance, regarding sodium valproate.</p>	

## Effective

## Rating: Requires Improvement

At the last inspection, the practice was rated Requires Improvement for the effective key question due to their performance in several Quality Outcomes Framework (QOF) indicators.

The practice remains rated as **Requires Improvement** for the effective key question. Although the practice improved their QOF performance, they remained below national childhood immunisation and cervical cancer screening targets. We also found five patients who had not been coded as pre-diabetic.

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y

### Older people

### Population group rating: Good

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. Those identified received a full assessment of their physical, mental and social needs.</li><li>• The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.</li><li>• The practice carried out structured annual medicines reviews for older patients.</li><li>• Staff had appropriate knowledge of treating older people including their psychological, mental and communication 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></ul>

## People with long-term conditions

## Population group rating: Requires Improvement

### Findings

- We found five out of seven pre-diabetic patients were not coded in the practice's records to ensure they were closely monitored. We discussed this with the provider, who said the patients were receiving patient-orientated tailored care.
- 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.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	77.0%	75.7%	76.6%	No statistical variation
PCA* rate (number of PCAs).	4.0% (10)	11.6%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	93.8%	90.2%	89.4%	No statistical variation
PCA rate (number of PCAs).	3.6% (3)	11.7%	12.7%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.



Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	80.0%	83.1%	82.0%	No statistical variation
PCA* rate (number of PCAs).	1.1% (1)	4.5%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	58.6%	65.2%	66.9%	No statistical variation
PCA rate (number of PCAs).	2.6% (13)	12.4%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	66.5%	71.9%	72.4%	No statistical variation
PCA rate (number of PCAs).	1.7% (15)	6.5%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	100.0%	89.3%	91.8%	Variation (positive)
PCA rate (number of PCAs).	7.1% (3)	5.2%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	71.9%	75.7%	75.9%	No statistical variation
PCA rate (number of PCAs).	2.2% (11)	9.4%	10.4%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

#### Any additional evidence or comments

We reviewed five medication reviews carried out for patients experiencing long-term conditions. All were carried out appropriately and in accordance with guidance.

Findings

- The practice had not met the minimum 90% for four of five childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for five of five childhood immunisation uptake indicators. The provider told us they experienced difficulty in getting patients to vaccinate their children due to hesitancy. However, the practice was close to achieving the 95% target for children aged one.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	70	74	94.6%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	67	88	76.1%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	72	88	81.8%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	73	88	83.0%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	74	89	83.1%	Below 90% minimum

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

## Working age people (including those recently retired and students)

## Population group rating: Requires Improvement

### Findings

- Cervical cancer screening was below target for the percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64).
- 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.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	66.8%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	63.0%	64.7%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	52.8%	55.1%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	100.0%	92.1%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	63.0%	56.7%	54.2%	No statistical variation

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

- Same day appointments and longer appointments were offered when required.
- 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 reviewed young patients at local residential homes.

**People experiencing poor mental health (including people with dementia)**

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- We were told that same day and longer appointments were offered when required.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	95.5%	86.1%	85.4%	No statistical variation
PCA* rate (number of PCAs).	2.2% (2)	12.3%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	100.0%	79.6%	81.4%	Variation (positive)
PCA rate (number of PCAs).	6.7% (1)	7.4%	8.0%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

## Monitoring care and treatment

The practice had engaged in quality improvement activity to review the effectiveness and appropriateness of the care provided.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	508.6	533.9
Overall QOF score (as a percentage of maximum)	91%	95.5%
Overall QOF PCA reporting (all domains)	2.5%	5.9%

	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

As part of the provider collaboration return, the practice sent three quality improvement activities carried out by the primary care network pharmacist and an independent medicines management optimisation service that advised the next steps for the practice. The practice had independently carried out a sodium valproate audit in January 2021.

Osteoporosis audit  
Calcium & Vitamin D audit  
Cow's milk allergy review

### **Osteoporosis audit**

The review aimed to identify patients at risk of calcium & vitamin D deficiency who may benefit from calcium & vitamin D supplementation. In addition, the review sought to ensure that prescribing calcium and vitamin D was in line with recommended national and local guidelines.

The practice was advised to review 840 patients.  
Recommended to reaudit in June 2022

### **Vitamin D audit**

Purpose of the audit:

- To review patients with a coded diagnosis of vitamin D deficiency or insufficiency and check for appropriate vitamin D treatment doses / maintenance doses.
- To identify and review patients 'at risk' of vitamin D insufficiency or deficiency in accordance to Department of Health's definition of 'at risk' groups.
- To identify and review the coded data for patients with recorded symptoms of vitamin D deficiency.
- To review patients currently prescribed vitamin D supplements.

The findings of the review was that there were 4148 patients at risk of vitamin deficiency and 3936 patients without vitamin D supplementation.

Recommended to reaudit in June 2022

### **Cow's milk allergy review**

The review looked at six patients and made recommendations of change where necessary.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-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
Every Tuesday, the practice hosted an in-house local well-being service where patients could be referred to speak with a trained health and well-being advisor.	

### Consent to care and treatment

#### The practice demonstrated that it 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.	N
We saw patient consent was recorded in patients' consultation notes before they underwent treatment. The practice had one DNACPR on record; we noted the question concerning whether there was communication with the patient or Welfare Officer had been completed.	

## Caring

**Rating: Good**

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion.**

	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

Source	Feedback
NHS Choices	Four of the eight comments recorded between September 2019 and May 2021 were five star. Staff were described as caring and friendly.
Online reviews	The practice is rated as 1.6 out of 5 stars based on 24 reviews online. The majority of negative comments related to patients feeling that staff were rude and inattentive, and difficulty getting an appointment.

### National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	88.2%	88.3%	89.4%	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 (01/01/2021 to 31/03/2021)	85.5%	86.8%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	92.4%	95.1%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	78.6%	81.3%	83.0%	No statistical variation

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

Any additional evidence
The practice took part in the national Friends and Family Test.

#### 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

#### National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	85.8%	92.0%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	N/A
There was no information available in different languages or easy read formats in the practice's reception area.	

Carers	Narrative
Percentage and number of carers identified.	78 (1%)
How the practice supported carers (including young carers).	The practice supported carers with priority appointments, flu jabs and health checks. The practice signposted carers to local community support groups.
How the practice supported recently bereaved patients.	Bereavement patients were referred to the local organisations.

## Privacy and dignity

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

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
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

# Responsive

# Rating: Good

## Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6:30pm
Tuesday	8am to 6:30pm
Wednesday	8am to 3pm
Thursday	8am to 6:30pm
Friday	8am to 6:30pm
Appointments available:	
Monday	8am to 6:30pm
Tuesday	8am to 6:30pm
Wednesday	8am to 3pm
Thursday	8am to 6:30pm
Friday	8am to 6:30pm

## Older people

Population group rating: Good

### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- There was a medicines delivery service for housebound patients.

## People with long-term conditions

Population group rating: Good

### Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

## Families, children and young people

Population group rating: Good

### Findings

- Additional nurse appointments were available until 6:30pm on a Monday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

## Working age people (including those recently retired and students)

Population group rating: Good

### Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 6:30pm on a Monday, Tuesday, Thursday and Friday. The practice is closed at weekends. When the surgery is closed urgent GP services are available via NHS 111.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

**People experiencing poor mental health (including people with dementia)**

**Population group rating: Good**

**Findings**

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

## Access to the service

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

National GP Survey results

	Y/N/Partial
Patients were able to make appointments in a way which met their needs.	Y <sub>1</sub>
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Partial <sub>2</sub>
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. Patients were asked to call at 8am daily to book an appointment two weeks in advance. The majority of GP appointments on the system were for telephone consultations, with two being blocked out daily for emergencies. Reception staff told us that all calls were triaged to a GP, who would decide if a patient needed to be seen.</li> <li>2. The practice did not have a hearing loop for patients who had difficulty hearing.</li> </ol>	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	56.1%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	65.5%	69.2%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	59.9%	65.7%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	71.7%	79.5%	81.7%	No statistical variation



Source	Feedback
For example, NHS Choices	Of the eight comments left, two referenced difficulty getting an appointment at the practice and getting through to the practice via telephone.

### Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	4
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Two out of four complaints concerned patients experiencing difficulty getting through to the practice and not knowing how long they would be on hold. We saw evidence that the practice was in the process of getting quotes to have a new call waiting telephone system installed.	

#### Example(s) of learning from complaints.

Complaint	Specific action taken
Prescription not signed	The provider discussed the case with the palliative nurse. The palliative care team were advised not to send prescription requests for urgent medication to the generic email address but to send them directly to the repeat prescription email.

## Well-led

Rating: Good

### Leadership capacity and capability

There was compassionate and inclusive leadership. The practice had identified challenges and had taken some action to address them.

	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.	N
Senior leaders had discussed succession, but a formal plan had not been created.	

### Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
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: Staff understood the vision of the practice but were not involved in it's creation.	

## Culture

### The practice had a culture which supported 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.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	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 had not received training in the duty of candour.</p> <p>Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.</p> <p>There were processes for providing all staff with the development they need; this included appraisals and career development conversations. All staff received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.</p> <p>The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.</p> <p>There were positive relationships between staff and teams.</p>	

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

Source	Feedback
Staff interviews	<p>Feedback from staff included:</p> <ul style="list-style-type: none"> <li>- Staff felt supported by the practice and felt that it was a family environment.</li> <li>- They felt leaders in the practice were visible and approachable.</li> <li>- Staff were encouraged to develop within their role and attend training.</li> <li>- They have yearly appraisals and regular team meetings.</li> <li>- They are given protected time for learning and development.</li> </ul>

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There were weaknesses in the overall governance arrangements, such as oversight of staff vaccination status, staff training, and the need to undertake risk assessments relating to the practice.	
The staff we spoke to were clear about their roles and responsibilities.	

## Managing risks, issues and performance

**There were some processes for managing risks, issues and performance, but there were areas that we overlooked.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
The staff we spoke to could not recall having specific major incidents training and had not seen the practice's business continuity plan. Following the inspection, the provider told us that staff had been briefed on what to do during a major incident and would undergo full training at the next staff meeting.	

**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

### Appropriate and accurate information

**There was a commitment to using data and information proactively to drive and support decision making. However, 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.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Arrangements for identifying, managing, and mitigating risks were not always adequate as risk assessments such as premises/security and health and safety were not carried out and we found evidence that patients were not always monitored effectively.	

## 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

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Staff were trained to carry out extra duties in response to a member of the secretarial team being on long-term leave, which included IT, Docman and EMIS sessions.	
A member of the nursing team was supported to complete their Master's degree. The practice had a regular training programme in place.	

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- **\*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#) ). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
- 
- ‰ = per thousand.