

Inspection Evidence Table

East Park Medical Centre - R P Pandya

(1-553136680)

Inspection Date:

Date of data download: 16/11/2022

Overall rating: Requires Improvement

The practice was rated as inadequate at the Care Quality Commission (CQC) inspection in March 2022 when we inspected the three key questions of safe, effective and well led as part of the Urgent and Emergency Care system wide inspections. The practice was placed in special measures and following the inspection warning notices in respect of Regulation 12 (Safe Care and Treatment) Regulation 13 (Safeguarding service Users from Abuse and Improper Treatment) and Regulation 17 (Good Governance) were issued.

This comprehensive inspection carried out in November 2022 covered all key questions and was to review improvements made and compliance with the warning notices for Regulation 12, 13 and 17.

Following our inspection, the practice is rated as requires improvement and removed from special measures. This is because: -

- Whilst significant improvements had been made by the provider, gaps remained across the practice systems to support safe, effective and well-led services.
- Systems and processes had been introduced but had not been in place for a sufficient amount of time to develop and become embedded within the practice.

Safe

Rating: Requires Improvement

At the last inspection in March 2022 we rated the practice as inadequate for providing safe services because there were no clear processes in place to ensure patients were safe. We found inaccurate safeguarding registers, infection prevention and control, recruitment procedures, staff training and the management of patients on high risk medicines was not effective.

At this inspection, we found that those areas previously regarded as inadequate had improved, though some areas required more development. Recently implemented systems and process needed to be embedded within the practice. The practice is therefore now rated requires improvement for providing safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in March 2022 the provider did not have systems, processes and practices embedded and operating effectively to enable proactive monitoring of safeguarding concerns.</p> <p>At this inspection in November 2022, we carried out remote clinical searches. We saw the safeguarding register and records of patients who were vulnerable were now completed and up to date. All patient records were appropriately coded, and reviews were documented.</p> <p>The practice provided us with updated safeguarding policies for both children and young adults, and vulnerable adults. The policies now included references to female genital mutilation (FGM), modern day slavery and referenced up to date national guidance.</p> <p>On review of the training matrix we saw all staff had now completed training at the appropriate level. Staff we spoke with understood the safeguarding processes and their responsibilities.</p> <p>Regular monthly safeguarding meetings were in place with involvement of both internal and external stakeholders. We reviewed 3 sets of minutes which documented discussions and reviews at the appropriate level.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in March 2022 a review of staff files showed gaps in relevant recruitment checks.</p> <p>We reviewed 4 staff files during our inspection in November 2022. All files reviewed were well organised with a standardised list of contents with all relevant recruitment checks in place.</p> <p>Some staff were employed and recruited by the Primary Care Network (PCN) to work across the PCN's range of practices. The practice did not have assurance that safe recruitment practices had been followed for these staff who regularly deliver care to the provider's patients. Managers had requested the copies of the information and DBS numbers from the PCN in an email dated 28 November 2022 but had not received a response at the time of our inspection.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: January 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: May 2022	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in March 2022 risk assessments for fire safety, Legionella and control of substances hazardous to health (COSHH) were not available in line with the provider's policy.</p> <p>At this inspection in November 2022 we found improvements had been in made but further work to strengthen this area was required.</p> <p>At this inspection we reviewed the Fire Risk Assessment (FRA) undertaken for both sites in June 2022. We saw evidence that actions had been completed for some of the recommendations and actions were in progress for others requiring external or structural changes. For example, we saw evidence that weekly fire alarm testing identifying zones had been undertaken consistently, fire drills had been carried out and records completed. However, a process had not been introduced to ensure emergency lighting had been tested as required.</p> <p>The provider had information and data sheets in place for chemicals used within the practice. However, an overarching risk assessment for Control of Substances Hazardous to Health (COSHH) had not been completed.</p>	

A Legionella risk assessment had been completed by an external company for both sites; all high risk actions identified had been completed with some lower risk actions ongoing. We saw regular flushing of outlets had been undertaken consistently since our inspection in March 2022.

An external company checked the water temperatures of a selection of outlets on a monthly basis. However, when we reviewed the water temperature log, it showed temperatures out of the safe range 24 times at the main site and 6 times at the branch site between September and the day of our inspection visit. The provider did not have an effective system and process in place to ensure the water temperature results were consistently reviewed and acted upon if out of range.

We saw evidence that gas appliances and lifts at the main and branch site had been tested and serviced by appropriately qualified professionals.

Window blinds fitted throughout the practice did not have safety devices in place to ensure the blind cord was secured safely and would not become a ligature risk if a patient became entangled. A risk assessment had not been carried out to review and mitigate the risk. However, since our inspection we have seen evidence the blind cords were placed on the risk register with actions underway to replace the blinds.

The provider did not have signage in place to indicate oxygen was kept on site, which in the event of a fire increased the risk of explosion. However, we highlighted this to managers and appropriate signs were put in place during our inspection visit.

The provider had scheduled building work planned to convert a toilet, within both the main and branch site to be used as a dedicated sluice area. This would lead to improvements in the management and disposal of clinical specimens and contaminated substances. The identified areas were locked and had appropriate, clear signage identifying the change in use.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 22 November 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
During our last inspection in March 2022 the provider was unable to demonstrate appropriate systems and processes in place to be assured infection prevention and control management was effective.	
At this inspection in November 2022 the practice appeared clean, tidy and uncluttered. Cleaning schedules for each clinical room and the overall environment were in place and completed consistently. A monthly infection	

prevention and control (IP&C) checklist had been developed and was completed by the practice manager. Any concerns and actions required were identified.

Review of information given to us by the provider showed all staff had completed training in infection prevention and control. Staff we spoke with told us what their responsibilities were and understood the roles of others.

The cleaning cupboard used to store COSHH products and cleaning equipment was appropriately locked. Disposable mop heads were changed each day and buckets and mop handles stored appropriately. COSHH data sheets, cleaning schedule folder, cleaning rotas and time scales for cleaning tasks were present.

An IP&C audit was carried out in January 2022 with all actions completed. A further audit was carried out with the Integrated Care Board (ICB) on 22 November 2022 and we were told the action plan was being developed.

Waste streams were appropriately segregated and stored securely while awaiting collection. However, the provider had not labelled sanitary bins to identify their use.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<p>Explanation of any answers and additional evidence:</p> <p>On review of the training matrix we saw all staff had completed appropriate training to allow them to respond to a medical emergency, including sepsis. Staff we spoke with understood how to identify a deteriorating patient, how they would manage the situation and get help.</p> <p>The provider now had the full range of recommended emergency medicines for general practice or a completed risk assessment to support a decision not to keep certain recommended medicines on site.</p> <p>The provider had relocated the emergency drugs to the reception area, adjacent to the emergency equipment to allow easier access. However, signage to indicate where the emergency equipment was located was not in place and the emergency medicines were stored within a locked cabinet with the key kept separately, this could potentially lead to a delay in being able to access required medicines in an emergency.</p>	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At this inspection in November 2022 our clinical searches showed patient reviews, referrals, tasks and letters had been managed appropriately. There were no patients waiting for a two week wait referral, 44 letters were pending, 10 were reviewed and no patient risk identified. Whilst there were 348 tasks pending 149 of these were to update staff. Review of 10 of the remaining 199 tasks did not identify any risks.</p>	

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	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>	0.62	0.71	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). (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>	8.0%	8.7%	8.5%	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	5.46	4.70	5.31	No statistical variation

Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	128.6‰	95.0‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.39	0.78	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	2.9‰	6.2‰	6.8‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y

There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>During our previous inspection in March 2022 we identified concerns relating to the management of medicines within the practice.</p> <p>At this inspection in November 2022 we found the practice had made significant improvements, but further work was required to embed these improvements.</p> <ul style="list-style-type: none"> • The provider had introduced an Emergency Drugs Monitoring Procedure which included a monthly check of medicines, the amount held and expiry dates. We saw completed checks had been carried out consistently since our previous inspection. All medication we reviewed was stored appropriately, held securely and in date. • The provider had relocated the emergency drugs to the reception area, adjacent to the emergency equipment to allow easier access. However, the emergency medicines were stored within a locked cabinet and key kept separately, this could potentially lead to a delay in being able to access required medicines in an emergency. • The provider now had the full range of recommended emergency medicines for general practice or a completed risk assessment to support a decision not to keep certain recommended medicines on site. • During our visit we reviewed 7 Patient Group Directions (PGDs), all were appropriately authorised in line with legislation. • The provider had developed and implemented a Cold Chain Policy which included the management of the vaccination refrigerators. We found the 2 refrigerators at the main site and 1 at the branch site were now managed consistently. We saw records showing twice daily temperature recordings completed on the days the practices were open. Data from data loggers in the main branch refrigerators was downloaded consistently. • The Cold Chain Policy included a monthly check of all stock in each refrigerator. The check included supplier, batch number, quantity and expiry date. All vaccines we reviewed were in date and stored appropriately. <p>We saw evidence on the refrigerator monitoring sheet that on 2 occasions in September the data logger had not been reset correctly, leading to 2 x 20 minute gaps in temperature monitoring. The provider had not investigated this as a significant learning event to identify if any education or training needs of individuals.</p> <p>At our previous inspection in March 2022 we had concerns regarding management of patients on high risk medicines and monitoring of patients' health whilst on specific medication when indicated. At this inspection our remote clinical searches showed the monitoring and review of patients on high-risk medicines had now been completed appropriately. Therefore, the provider was able to assure themselves that it remained safe to prescribe medicines to patients where specific, frequent, monitoring and review was required.</p> <p>During our previous inspection in March 2022 clinical searches highlighted that medication reviews were being undertaken. However, it was not always clear that all medicines had been reviewed and necessary actions taken. At our inspection in November 2022 we reviewed 5 sets of patient records coded that a medication review had been conducted. Whilst documentation had improved, it was not clear if the patient had been involved in the review and a template to ensure consistency of reviews was not used.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded since the last inspection in March 2022:	4
Number of events that required action:	4
<p>Explanation of any answers and additional evidence:</p> <p>The provider had a system to record and act on significant events and near misses. However, we identified an issue that should have been reviewed using a significant event analysis (SEA) that the provider had not recognised. We requested a SEA was undertaken to identify risk and any learning.</p> <p>We reviewed examples of significant events, investigations and learning outcomes. We saw evidence of meeting minutes which showed significant events were a standing agenda item and the dissemination of learning had occurred.</p>	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken/ learning outcome
A urine sample was left at reception which was overlooked and not checked in on the system.	System in place that reception staff now inform clinical staff when a sample has arrived and waiting to be processed via the IT communication system
One of the staff members tripped, no significant harm noted	Review of safety in the area the trip occurred

Safety alerts	Y/N/Partial
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There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
We saw examples of appropriate actions taken on recent alerts, for example, regarding sodium valproate.	

Effective

Rating: Requires Improvement

At the last inspection in March 2022 we rated the practice as inadequate for providing effective services because the practice was unable to demonstrate that patients' needs, care and treatment followed evidence based guidance and the appropriate patient reviews and monitoring had been completed.

At this inspection, we found that those areas previously regarded as inadequate had improved significantly due to systems and practices implemented, which had led to improved safety for patients. However, some areas required further development and recently improved systems and processes needed to be embedded. The practice is therefore now rated requires improvement for providing effective services.

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 were delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y

Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
The practice prioritised care for their most clinically vulnerable patients	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our last inspection in March 2022 we found concerns relating to staff knowledge of current evidence-based practice, which was not being followed, the assessment of immediate and ongoing needs, lack of care plans, assessment of and regular review of patient's health.</p> <p>At our current inspection in November 2022 we saw improvements had been made.</p> <p>The provider had implemented systems and processes to ensure patients' treatment was regularly reviewed and updated as required. Regular audits of the clinical system were undertaken to identify patients who required a health review or monitoring. Patient details would be forwarded to the administration team to invite patients to book an appointment.</p> <p>Our remote clinical searches identified patients were reviewed and monitored in line with current evidence based practice. Monitoring of patients taking a range of high risk drugs, medication usage and patients suffering long term conditions were reviewed and no risk identified.</p>	

Effective care for the practice population

Findings

- 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.
- Care plans were in place for elderly frail patients.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. The provider had offered health checks to 871 of the 1521 patients eligible. The practice was working with the Primary care Network (PCN) and health checks were now available on a Saturday and into the evening.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice had a system to identify people with mental illness, severe mental illness, and personality disorder who required their physical health to be assessed and monitored.
- During our last inspection in March 2022, 14 out of 69 patients diagnosed with dementia had been subject to a health review. At this inspection the numbers had slightly improved with 28 out of 76 reviewed. However, further work is required in this area.

Management of people with long term conditions

Findings

- Patients requiring high dose steroid treatment for severe asthma episodes were followed up in line with national guidance to ensure they received appropriate care.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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 COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021))(NHS England and Improvement)	89	94	94.7%	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) (01/04/2020 to 31/03/2021))(NHS England and Improvement)	85	89	95.5%	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)	86	89	96.6%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and	87	89	97.8%	Met 95% WHO based target

rubella (one dose of MMR) (01/04/2020 to 31/03/2021) <small>(NHS England and Improvement)</small>				
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) <small>(NHS England and Improvement)</small>	109	113	96.5%	Met 95% WHO based target

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

Cancer Indicators	Practice	SICBL average	England	England comparison
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). (30/06/2022 to 30/06/2022) <small>(UKHSA)</small>	63.4%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) <small>(UKHSA)</small>	62.5%	56.4%	55.4%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) <small>(UKHSA)</small>	66.8%	39.6%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) <small>(UKHSA)</small>	48.7%	54.4%	66.8%	N/A

Any additional evidence or comments

The practice provided their own unverified data for cervical cancer screening, this showed an improvement from our verified data. The practice data showed screening performed in the last 3 years and 6 months for patients aged 25-49 was 64.3% and for screening performed in the last 5 years and 6 months, for patients aged 50 -64 was 77.2 %.

The provider had commenced extended hours one evening a week for cervical screening to be carried out following patient feedback that it was difficult to attend during the routine clinic times.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the majority 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.	N
<p>During our previous inspection in March 2022 the practice could not provide evidence that unplanned admissions and readmissions were regularly reviewed and evidenced only a limited quality improvement program. At our inspection in November 2022 managers told us they had not introduced a system to review unplanned admissions and readmissions to hospital.</p> <p>Whilst we did not see a formalised targeted quality improvement program, we saw evidence of quality improvements ongoing within the practice. We saw evidence of clinical audits undertaken within the practice which identified outcomes and next steps undertaken since our last inspection in March 2022.</p> <p>Review of the Monthly PCN Meeting Minutes evidenced on going details, discussion and actions to improve care and treatment for the wider PCN patient population including the practice. This included improving extended access, anticipatory care and delivery of Covid Vaccinations Phase 5.</p> <p>Managers we spoke with told us they had developed a range of clinical searches which they ran monthly to identify patients requiring review and monitoring. They then used this information to ensure the patients received appropriate safe care and treatment.</p>	

Any additional evidence or comments
<p>An audit of females of childbearing age and on teratogenic drugs was carried out to identify any patients who had not been be made aware of the increased risk of birth defects whilst taking teratogenic drugs and to make them aware of the recommendations regarding contraception. The outcome of the audit was all 13 patients identified were contacted and provided with appropriate information. We saw evidence of a rage of regular monthly audits being undertaken to prevent recurrence.</p> <p>An audit of patients taking bisphosphonates medicines was carried out to identify patients who had been prescribed the drug for 5 years and not had a drug holiday of 1 year to reduce the risk of bone fragility caused by long term use. The outcome of this audit was 8 patients were identified as needing a drug holiday and contacted. We saw evidence plans were in place to run a further audit in 12 months.</p>

Effective staffing

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

	Y/N/Partial
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Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in March 2022 we found the practice had been unable to demonstrate staff had the skills, knowledge and experience to carry out their roles. Ongoing competence was not assessed, appraisals were not carried out and essential learning was not completed.</p> <p>At our inspection in November 2022 we found improvements.</p> <p>The provider had introduced a system of audit to review all clinical staffs' consultations. We saw completed audit proformas for 5 sets of consultations which covered a variety of checks including history taking, decision making and prescribing decisions. The audits had been completed for all levels of permanent clinical and PCN staff.</p> <p>The practice had introduced systems and processes to assure themselves staff had completed the provider's essential learning. Staff we spoke with told us a much greater emphasis was placed on training and development and they received protected learning time to complete these.</p> <p>All staff had received an annual appraisal at the time of our inspection in November 2022. The appraisals supported staff training and development.</p>	

Coordinating care and treatment

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

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

Explanation of any answers and additional evidence:

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.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our previous inspection in March 2022 the provider had not focused on health reviews as the Covid Pandemic temporarily changed priorities for health care.</p> <p>At this inspection in November 2022 we saw improvement in systems and processes. The provider was working alongside other practices within the PCN in relation to a new initiative to offer health checks on a Saturday and into the evenings which had increased uptake. However, further work was required to ensure all patients had access to appropriate health assessment. For example, 46 out of 76 patients with a diagnosis of dementia and 650 out of 1521 patients eligible for an NHS health check had not received a health review.</p> <p>Review of patient records had documented discussions had occurred between staff and patient and carers as required in relation to changes in care. However, we reviewed 5 sets of patient records coded that a medication review had been conducted and it was not clear if the patient had been involved in the review.</p>	

Any additional evidence or comments

The practice was able to refer to the social prescriber through the primary care network (PCN) who was able to refer patients to groups providing weight loss support, smoking cessation, financial support and befriending groups.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches:</p> <p>During our previous inspection in 2022 we identified concerns relating to the requirements of The Mental Capacity Act 2005 and staff understanding of the requirements. We found a telephone health assessment had been undertaken for a patient diagnosed with dementia without their participation with no documented evidence of assessment of capacity or consent.</p> <p>At this inspection in November 2022 our clinical notes review of patients coded as having dementia identified patient involvement in assessments with capacity assessed and documented if appropriate.</p> <p>Our clinical review of notes where a DNACPR decision had been recorded, had identified where possible that the patient's views had been sought and respected, we saw that information had been shared with relevant agencies.</p> <p>Information sent to us by the provider showed all staff had completed essential training in Mental Capacity and Deprivation of Liberty Safeguards. Staff we spoke to could explain the principles and requirements of the Mental Capacity Act 2005.</p>	

Caring

Rating: Good

At the last inspection in November 2022 we did not inspect the caring key question as the inspection was part of the system review into urgent and emergency care. The methodology used was to inspect safe, effective and well led key questions with limited information relating to access. At the inspection in June 2016, caring was rated as good.

The data and evidence we reviewed in relation to the caring key question as part of this inspection showed the practice continued to deliver a caring service. Therefore, there is no change to the rating for providing caring services.

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
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National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who 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)	77.9%	78.4%	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)	68.0%	76.4%	83.5%	Variation (negative)
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)	85.9%	88.2%	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)	61.8%	63.6%	72.4%	No statistical variation

Any additional evidence or comments

The provider had not acted on the results of the latest GP patient survey. There was no analysis of the practice results or action plan in place to improve.

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

Any additional evidence

The provider had a suggestion box in reception where patients could leave comments. However, the provider told us that since the Covid pandemic and reduction in people coming to the surgery in person the suggestion box had not been well used.

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 Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who 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)	84.8%	84.7%	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.	85 carers registered with the practice which is 0.8%
How the practice supported carers (including young carers).	<p>The provider had a Carer Identification Protocol in place, this included a specific section for young carers. A poster with information signposting to support was in the reception area at both the practice sites.</p> <p>The practice offered flexible appointments for patients who need carers and for carers working around the people they look after.</p> <p>The practice had made the vaccination of carers a priority during the Covid Pandemic</p>
How the practice supported recently bereaved patients.	The provider had a Bereavement Protocol and leaflet available for recently bereaved people. This included details on arrangements required, who to contact and details of support groups. However, it did not include any aspects relating to the requirements of specific cultures when a person dies.

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

Responsive

Rating: Good

At the last inspection in November 2022 we did not inspect the responsive key question as the inspection was part of the system review into urgent and emergency care. The methodology used was to inspect safe, effective and well led key questions with limited information relating to access. At the inspection in June 2016 responsive was rated as good.

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as 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	Main Site - Time	Branch Site -Time
Opening times:		
Monday	8 am – 9.00pm	8 am – 6.30pm
Tuesday	8 am – 6.30pm	8 am – 6.30pm

Wednesday	8 am – 6.30pm	8 am – 6.30pm
Thursday	8 am – 6.30pm	8 am – 1.30pm
Friday	8 am – 6.30pm	8 am – 6.30pm
Appointments available:		
Monday	8 am – 8.30pm	8 am – 6.30pm
Tuesday	8 am – 6.30pm	8 am – 6.30pm
Wednesday	8 am – 6.30pm	8 am – 6.30pm
Thursday	8 am – 6.30pm	8 am – 1pm
Friday	8 am – 6.30pm	8 am – 6.30pm

Further information about how the practice is responding to the needs of their population

- Patients over 75 years of age 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 liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Flexible appointments were available to take into account school opening and closing times.
- The main site was open until 9pm on a Monday when pre-bookable appointments were available for patients to attend for cervical screening alongside a GP clinic.
- The practice had telephone requests in place for housebound patients to order repeat medication.
- The practice had a dedicated telephone line for community teams, nursing and residential homes to ensure ease of access
- The practice held a register of patients living with a learning disability, mental health concerns and palliative needs.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- All patients who did not attend the practice following recall for monitoring received a follow up telephone call and were offered another appointment.

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	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y

Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <p>On the day of our inspection visit we reviewed the appointment system and saw that GP appointments were available for routine and emergency appointments in the morning and afternoon clinics. Wait times for routine blood test were 10 days, with availability for urgent bloods to be carried out on the day.</p>	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	58.0%	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)	46.4%	47.3%	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)	62.5%	51.1%	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)	53.6%	65.5%	71.9%	Tending towards variation (negative)

Any additional evidence or comments

The provider had not acted individually on the results of the latest GP patient survey. There was no practice action plan in place to identify concerns or actions to improve. However, the provider was working with the Primary Care Network (PCN) to improve extended access throughout the whole PCN.

Source	Feedback
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NHS Choices	Positive feedback from a patient who had been with practice since 1973. Always had a good service provided by the doctors and nurses and the front reception staff. Helpful surgery manager, well done keep up the good work.
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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 since our previous inspection in March 2022.	3
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
Any additional evidence or comments	
During our inspection we reviewed 3 complaints and the provider had managed all in line with the complaints procedure. However, when an ongoing complaints investigation was required the procedure was not clear about how a complainant would be kept updated with the progress being made and expected response times.	

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

Example of learning from complaints.

Complaint	Specific action taken
Complaint related to the reception staffs' attitude. Staff incorrectly told a patient they had arrived late for an appointment and their prescription wasn't ready as it should have been.	Discussed with staff on duty at the time and shared at practice meetings. Staff reminded to ensure all communication was appropriate, professional and polite.

Well-led

Rating: Requires Improvement

At the last inspection in March 2022 we rated the practice as inadequate for providing well led services because the clinical leadership team were unable to demonstrate they had the skills or capacity to deliver quality sustainable care and monitor governance processes effectively. The practice had no formal no vision, strategy or improvement plan to improve the quality of care available.

At this inspection, we found that those areas previously regarded as inadequate had improved, though some areas required more development. Recently implemented systems and process needed to be embedded. The practice is therefore now rated requires improvement for providing well led services.

Leadership capacity and capability

Leaders could not always demonstrate that they understood all the current challenges to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our last inspection in March 2022 concerns were identified related to the leadership within the practice. Leaders did not demonstrate understanding of the challenges to manage quality and sustainability, have full oversight of clinical care, awareness of current roles within health care or ensure effective processes were embedded to drive efficiency and ensure safety in the practice. There was no leadership development to ensure the future leadership of the practice.</p> <p>At this inspection in November 2022 the leaders and managers within the practice had taken action to introduce systems and processes to assure themselves they were delivering good quality care to patients in relation to the finding at our previous inspection in March 2022. However, managers had not identified further issues and concerns we found during our November visit.</p> <p>We saw evidence that a suite of clinical searches had been introduced and run regularly to ensure patients received appropriate recall for health reviews and monitoring. However, we could not be assured these were fully embedded within the practice at the point of our inspection.</p> <p>Since our last inspection, the provider had introduced new roles within the practice to support staff and the future of the practice. A Freedom to Speak up Guardian, external to the practice, had been identified and all staff were aware of the role, responsibilities and how to contact them. A plan was in place to develop the future leadership within the practice with the appointment of a Deputy Practice Manager.</p> <p>At our previous inspection in March 2022 the practice website was not up to date, we were told the provider was unable to update information themselves. Since then, the provider had changed their website, this enabled the practice to update information. However, not all information was correct as the website had two different versions of opening times included and the patient feedback section did not work.</p>	

Vision and strategy

The practice had a vision, but it was not supported by a 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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: At our last inspection in March 2022 the provider had not developed a vision or set of values with a credible strategy to deliver high quality, sustainable care. At this inspection the provider had not developed a specific vision or set of values, but the statement of purpose included a mission and vision statement with aims and objectives. Staff we spoke with could explain the priorities within the statement of purpose and told us patient care was their number one priority. However, staff, patients and external partners had not been involved in developing the mission and vision statement. The provider had not developed a strategy to allow progress against the delivery of the mission and vision statement. However, managers told us they planned to have quarterly discussions to monitor the progress and review the data. At the time of our inspection, meetings had not commenced.	

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:	

At our previous inspection in March 2022 not all staff had completed equality and diversity training. Review of information given to us by the provider showed all staff had now completed training in equality and diversity. Staff we spoke with were able to explain the principles involved.

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

Source	Feedback
Staff	Staff told us working at the practice was like being part of a family, they felt well supported by the team and all managers. The leaders were visible and approachable. They were all confident that they could raise concerns and they would be listened too.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our last inspection in March 2022 we found concerns relating to governance within the practice.</p> <p>At our inspection in November 2022 we found systems and processes had been implemented leading to significant improvements to governance within the practice. However, the system and processes had not been in place long enough to develop, evolve and ensure improvements were embedded and had become part of normal practice.</p> <p>The provider had ensured all staff had completed appropriate essential training and this was now monitored, and actions taken if staff did not complete training relevant to their role.</p> <p>Safeguarding systems and processes had been improved and medical records were appropriately coded.</p> <p>Our review of the clinical systems found patients on high risk medicines and management of patients with long term conditions had been managed appropriately.</p> <p>Whilst the practice held regular practice meetings before the last inspection in March 2022, the meeting agenda did not ensure all elements of good governance was consistently covered. Review of meeting minutes at our inspection in November 2022 showed an improved agenda and included the elements required to ensure effective governance were consistently discussed and shared with staff.</p> <p>At our previous inspection in March 2022 we found staff recruitment files to be poorly organised and they did not contain information to prove the provider's recruitment processes had been followed. At our inspection in November</p>	

2022 we reviewed 4 staff recruitment files and found them well organised. All included a content list, consistent and appropriate information and qualification checks were in place to ensure patient safety. Further work was required in relation to the information pertaining to PCN staff to ensure all the relevant recruitment and training documents were in place.

Managing risks, issues and performance

There were processes in place for managing some risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our last inspection in March 2022 the provider did not have oversight across systems and processes in place to ensure patient safety.</p> <p>At our inspection in November 2022 the provider had made significant improvement to systems and processes to improve oversight and deliver safe patient care. However, the improvements were relatively recently introduced, did not cover all aspects of risk and required embedding with the practice.</p> <p>A number of risk assessments relating to environmental risks had been completed since our previous inspection. However, an overarching risk assessment for Control of Substances Hazardous to Health (COSHH) had not been undertaken. Further work was required in relation to fire safety, Legionella and infection prevention and control risks to embed and develop systems and processes to ensure safety.</p> <p>The provider had recently introduced a risk register for both sites, this included ratings and scores to identify seriousness with actions and timescales for completion. We saw evidence that appropriate risks which could affect the practice were included on the risk register, assessments had been completed and actions taken as identified. However, due to the recent introduction of the risk register it had not yet been added to the governance agenda as a standing item and was not embedded within the practice.</p> <p>At our previous inspection in March 2022 the provider had not undertaken audit of clinical staffs' consultations and prescribing practice. At the inspection we saw completed audits of all clinical staff, including PCN staff working at the practice, had been undertaken to assure the provider of ongoing competence and good clinical decision making. However, at the time of our inspection there was no formal process to identify the frequency, quantity and responsible individuals to ensure the audits were continued.</p>	

Whilst we did not see a formalised targeted improvement program, we saw evidence of quality improvements ongoing within the practice and the PCN. We saw evidence of clinical audit undertaken within the practice which identified outcomes and next steps undertaken since our last inspection in March 2022.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in March 2022 we found limited evidence that data and audits had been completed to review quality and improve service provision. We found safeguarding concerns had not been appropriately coded to easily identify a patient at risk.</p> <p>During our inspection in November 2022 we found appropriate health reviews and monitoring of patients' conditions had been completed at the correct time and before prescribing medicines. On reviewing a sample of clinical records, we found information was accurate, reliable and correctly coded with the relevant clinical codes.</p> <p>The provider had implemented systems and processes to ensure patients' treatment was regularly reviewed and updated as required. Regular audits of the clinical system were undertaken to identify patients who required a health review or monitoring. Patient details would be forwarded to the administration team to invite patients to book an appointment.</p>	

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 external partners to sustain high quality and sustainable care but did not always involve the public and staff.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in March 2022 the provider had not collected patient feedback in the previous 12 months.</p> <p>During our inspection in November 2022 the provider had not implemented any system to collect patient feedback. The link to the Family and Friends Test on the website was not active. However, verbal feedback from a patient regarding confidentiality within the reception area of the main site had led to changes in how patients received and managed at reception. This led to a higher level of patient confidentiality being achieved.</p> <p>We saw evidence of minutes from the patient participation group (PPG) meetings which occurred monthly. These included information and discussion on actions required to improve the provider's website and services. Meeting minutes were available on the practice website.</p> <p>The provider had not carried out a staff satisfaction survey. However, staff told us they were able to make suggestions relating to the development and improvements of the service which were reflected in its delivery.</p>	

Feedback from Patient Participation Group.

Feedback
Following the previous inspection in March 2022 the PPG told us they had been involved in decisions made to improve that practice, the services and the website. The managers and leaders were described as very engaged with the PPG and involved them in decisions about improvements. PPG meetings occurred regularly on a monthly basis with involvement of the senior practice staff.

Any additional evidence

Following staff feedback and discussion changes had been made to how vaccines were stored within the refrigerators to improve safety and reduce the risk of staff selecting an incorrect vaccine.

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

At our previous inspection in March 2022 staff had not all completed the providers identified essential training. Since then we have seen evidence that all staff had completed essential training. Staff we spoke with told us the provider now had a greater focus on training and learning, with completion discussed routinely at meetings. We saw minutes of meetings which confirmed this.

Whilst we did not see a formalised targeted improvement program, we saw evidence of quality improvements ongoing within the practice and the PCN. We saw evidence of clinical audit undertaken within the practice which identified outcomes and next steps undertaken since our last inspection in March 2022.

Review of the Monthly PCN Meeting Minutes evidenced on going details, discussion and actions to improve care and treatment for the wider PCN including the practice. This included improving extended access, anticipatory care and delivery of Covid Vaccinations Phase 5.

Notes: CQC GP Insight

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5

No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

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

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

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

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

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

Glossary of terms used in the data.

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