

# Care Quality Commission

## Inspection Evidence Table

### Norton Medical Centre (1-552779884)

Inspection date: 15/16 and 30 November

Date of data download: 10 November 2022

## Overall rating: Good

We last inspected Norton Medical Centre on 23 September 2015, at which time the practice was rated as good in each of the five key questions.

We have again rated this practice as good.

## Safe

## Rating: Good

### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>The provider told us that staff employed prior to 2015 (all of them back office and administration staff) had not had a DBS check. The staff did not have any forward facing patient contact or</li></ul>	

Safeguarding	Y/N/Partial
<p>chaperone duties, The operational manager assured us that they would complete a risk assessment and include the assessment in their business plan.</p> <ul style="list-style-type: none"> <li>The provider told us that they completed a monthly audit of Do Not Attend (DNA) patients and any patient or children identified with a previous DNA would be followed up with the safeguarding team.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10/11/2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: 20/05/2020 Actions from fire risk assessment were identified and completed.	Y

## Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 03/11/2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We saw evidence that a premises cleaning audit was completed August 2022, safe management of equipment audit November 2022, hand hygiene audit October 2022 and a Control of Substances Hazardous to Health (COSHH) risk assessment November 2022.</li> <li>We saw that the management of clinical waste was handled by a third-party contractor off-site. We checked the storage bins for clinical waste and they were in a locked area.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice team leaders in all departments reported on resource and capacity on a monthly basis. This ensured that any shortfalls or gaps in resource could be filled for other teams as required.</li></ul>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Appropriate referral, managing test results and summarising records policies were in place. The provider told us that there was a slight backlog of summarising notes going back to August 2022. The operational manager gave us their assurance that summarising backlogs were currently being overseen by the team leader and admin staff allocated to prioritise any potential high risk notes.</li></ul>	

- We saw a risk assessment that identified the level of risk associated with relevant patient records. There were 121 associated records identified which were prioritised into 2 categories for example, patients that had not transferred from a system one practice and there was insufficient information on their record, and any records that indicated any potential safeguarding concern. The risk assessment indicated that the summarising backlog should be completed in the next 6 weeks.
- A review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.

## Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.94	1.04	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) (NHSBSA)	8.7%	8.3%	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 Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.36	5.43	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	267.4‰	240.4‰	128.0‰	Tending towards variation (negative)
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)	0.44	0.53	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	6.6‰	6.0‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	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.	Y
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 data-bbox="57 1704 1535 1749">Explanation of any answers and additional evidence, including from clinical searches.</p> <ul data-bbox="105 1783 1535 2045" style="list-style-type: none"> <li data-bbox="105 1783 1535 1895">• Appropriate policies were in place for example, drug storage protocol, safe secure handling controlled drugs policy, repeat prescription requests and annual declaration for the safe management of controlled drugs 2021.</li> <li data-bbox="105 1939 1535 2045">• The clinical review of patients notes identified that all patients reviewed on High Risk Medicine methotrexate (used to treat conditions such as rheumatoid arthritis) had received the appropriate monitoring.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>The clinical review of patients notes identified that all patients reviewed on High Risk Medicine Direct-Acting Oral Anticoagulants DOAC (known as a blood thinner to treat heart disease) had received the appropriate monitoring.</li> </ul>	

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

### The practice learned and made improvements when things went wrong and had a system 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.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	9
Number of events that required action:	9

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

Event	Specific action taken
Patient covid vaccine administered no consent granted by family.	Clinical system checked for consent records and procedure updated for gaining consent from family members whose relatives are in care settings.
Package handed over to reception that was incorrectly stored at the wrong temperature.	Extra staff training and policy reviewed for packages that requires storage at below 25c.

Safety alerts	Y/N/Partial
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: <ul style="list-style-type: none"> <li>We carried out remote clinical searches and a review of a random sample of clinical records found there were appropriate arrangements in place to respond to patient safety and medicine alerts.</li> <li>There was a 'Dissemination of Drug Alerts, Patient Safety Notices, Guidance and Formularies Protocol', which staff knew how to access. We saw a summary and log of alerts that had been received and actioned by the practice. For example, a Medicines and Healthcare products</li> </ul>	

Regulatory Agency (MHRA) alert that indicated there was a supply disruption and this did not affect any patients of the practice and was for information only.

## Effective

## Rating: Good

At our last inspection on 23 September 2015 we rated the practice as good for providing effective services. At this inspection, we found the provider had maintained this standard and was still rated as good.

*Quality and Outcomes Framework (QOF) requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	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 prioritised care for their most clinically vulnerable patients.	Y

### 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.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.



- Health checks were offered in the home for housebound patients.
- The practice employed a Clinical Pharmacist who was responsible for prompt and proactive responses to safety alerts, medication shortages and urgent medication queries as well as a safe prescribing.
- 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.
- Reasonable adjustments were made for learning disability patients to promote annual health checks by offering in surgery appointments with the same, Lead GP, who had a protected day for reviews, which consisted of 30 minutes with the health care assistant (HCA) and 15 minutes with the GP.
- The practice provided various counselling sessions for all patients. The practice employed a patient liaison officer, who could access services for example; Social Prescribers, Cancer Support Workers, Mental Health Practitioners and Health and Wellbeing Coaches.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Our clinical review of patients showed that the majority had received appropriate monitoring and prescribing for their ongoing long-term condition needs.
- 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 COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.



Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	41	44	93.2%	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)	35	37	94.6%	Met 90% minimum
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)	35	37	94.6%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	35	37	94.6%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	36	40	90.0%	Met 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>

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	78.3%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	65.5%	59.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	69.4%	66.8%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	62.6%	61.1%	55.4%	No statistical variation

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

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The 'How am I driving' statistics for the year April 2022-March 2023, and which the practice used to assess their ongoing performance, showed that the latest cervical screening figures were 88.4.% for persons aged 25-49 and 92.8% for persons aged 50-64. As these figures are not yet published and unverified, they cannot be used as a direct comparison.</li> </ul>

## Monitoring care and treatment

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

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

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

Some examples of audits included:

- Audit of children safeguarding using 'Child Safeguarding Toolkit'. The toolkit was designed to record specific concerns during a patient/child consultation to indicate the safe elements of the consultation and associated record keeping. The original search identified 120 consultations with 76% recorded correctly. As subsequent audit identified 113 consultations that identified 86% recorded correctly.
- Audit of cervical screening to ensure appropriate guidance was followed in line with national guidance and to promote patient understanding, the implications of screening and timely follow up.

### 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

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Y
<p>Explanation of any answers and additional evidence,</p> <ul style="list-style-type: none"> <li>• Our clinical review of notes where a DNACPR decision had been recorded, identified that where possible the patients views had been sought and respected, we also saw that information had been shared with relevant agencies.</li> <li>• The provider had implemented a DNACPR protocol which included a system generated recall and review following a 10 month period. We saw example reminder letters generated by the clinical system.</li> </ul>	

## Responsive

## Rating: Requires improvement

At our last inspection on 23 September 2015 we rated the practice as good for providing effective services. The data and evidence we reviewed in relation to the responsive key question as part of this inspection suggested we needed to review the rating for responsive at this time. At this inspection, we found the provider was rated as requires improvement.

### 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.	Partial
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice continued to monitor and seek improvements to access for patients. They were aware that access remained a key issue for the practice and recognised the ongoing difficulty in patients getting through to the practice by telephone. The provider had engaged with the ICB to develop and inform a separate access and capacity plan.</li> </ul>	

Practice Opening Times	
Day	Time
<b>Opening times:</b>	
Monday	8am – 6pm
Tuesday	8am – 6pm
Wednesday	8am – 6pm
Thursday	8.30am-12.00pm, 2.00pm-6.00pm
Friday	8am – 6pm
Saturday	8am – 11.30am Appointments only
<b>Appointments available:</b>	
Monday	8:30am – 6pm
Tuesday	8:30am – 6pm
Wednesday	8:30am – 6pm
Thursday	8:30am – 12:00pm and 3pm – 6pm
Friday	8:30am – 6pm

Saturday	8am – 11.30am Appointments only
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**Further information about how the practice is responding to the needs of their population**

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families’ wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Priority appointments for blood tests were available 8.00am-8.30am for patients who have fasted, for working age patients and for school age children so that they did not need to miss school
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

**Access to the service**

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	N
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice continued to monitor and seek improvements to access for patients. They were aware that access remained a key issue for General Practice and was an important marker for</li> </ul>	

patient satisfaction. They had carried out an audit to check access indicators, such as whole time equivalent of GPs, number of GP sessions and appointment availability.

- We spoke with Patient Participation Group (PPG) members and they told us that the provider had committed to implement changes to their appointment system and they had already done so but had not communicated the changes effectively to the community. The PPG told us that appointments could be booked at least 2 weeks in advance however, the provider had recognised some weaknesses in them communicating the message to the local community.
- At a recent meeting of the PPG in early November the provider had committed to set up a separate social media page to promote the appointment messaging with the support of local businesses to assist the practice in gaining additional communication channels with the local community.
- We saw that extended hours was provided by Hartlepool and Stockton Health (HASH) GP enhanced access service on an evening and weekend seven days a week.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	7.4%	N/A	52.7%	Significant Variation (negative)
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)	23.3%	52.2%	56.2%	Variation (negative)
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)	22.6%	52.6%	55.2%	Significant Variation (negative)
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)	48.5%	70.8%	71.9%	Variation (negative)

### Any additional evidence or comments

- The practice had recognised that some patients had difficulties to access the surgery on the telephone. The practice had implemented an access and capacity plan in conjunction with the ICB. The practice had implemented an appointment cancellation option, sourced a new telephony



system to be installed in January 2023 and staffing numbers had increased the later part of 2021 into 2022. The provider had also restructured its capacity for the advanced clinical practitioner team which allowed and admin GP additional time to prevent delays in treatment.

- The practice had also restructured its nursing and health care assistant team. This meant any non-clinical administration completed by the nursing team was now performed by the administration team which increased nursing clinical capacity
- We looked at data provided to us for the last 3 months (September – November 2022). The data showed that between 1 September 2022 and 8 December 2022 a total of 16887 calls were answered out of a total of 20817 offered. The average waiting time was 2 minutes 7 seconds. The provider told us they were implementing a new cloud based telephone system in January 2023. At the last PPG meeting in November the group and the provider agreed to meet in March 2023 to review the new data for the new telephone system that is due to be installed January 2023.
- The practice had received 22 complaints in the last year (January 2022 to November 2022) and 8 of these related to access and appointments. We examined in detail 4 of these which were recorded in a 'reflective practice forum'. The reflective practice forum was used to ensure other clinicians and relevant staff were informed and shared learning from complaints. Information about how to complain was readily available.

Source	Feedback
NHS Choices	We saw that the practice had received 10 reviews on NHS choices over the last 12 months. They had received 3 one star reviews, 1 two star review, 2 three star reviews and 4 five star reviews. All the reviews in the reviews in the 1 to 3 star category related to appointments and getting through to the practice by telephone. The five star review were all complementary regarding the support patients had received.

## 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.	22
Number of complaints we examined.	22
Number of complaints we examined that were satisfactorily handled in a timely way.	22
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>We examined in detail 4 out of 22 complaints which were recorded in a 'reflective practice forum'. The reflective practice forum was used to ensure other clinicians and relevant staff were informed and shared learning from complaints.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patients family complained regarding poor communication and appointments.	The patient received an appropriate response from the provider and the relevant clinician completed a full investigation.
Patient complaint regarding repeat prescription	The provider investigated the complaint and provided a full response to the patient. The importance of recording patient messages was re-iterated with practice staff concerned.

## Well-led

## Rating: Good

At our last inspection on 23 September 2015 we rated the practice as good for providing a well led service. At this inspection, we found the provider had maintained this standard and was still rated as good.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>We received 15 staff questionnaires and staff told us that management were very approachable, felt supported and staff enjoyed working at the practice. Other comments we noted was that internal communication could be improved in respect of recording patient contact discussions and an improved telephone system.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>We saw that the practice had a business plan which included their values and mission statement and succession planning review of staffing levels over the next 2 – 5 years.</li></ul>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We saw that the practice had a number of policies in place to encourage freedom to speak up and raising concerns for example a whistleblowing policy, major incident policy and business continuity policy.</li> <li>The practice had a process for dealing with bereaved patients and their family members when support was needed. We also saw a process for supporting carers.</li> <li>The practice had a reciprocal agreement with another practice in the PCN for a speak up guardian arrangement.</li> </ul>	

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

Source	Feedback
Staff questionnaires	<ul style="list-style-type: none"> <li>We received 15 staff questionnaires and all of them were very complimentary about working at the practice and staff felt supported and the staff and management worked well as a team. Staff said the management were accommodating and flexible to working hours in respect to work life balance.</li> <li>Staff told us that they held regular meetings and updates for example secretaries meetings, interdepartmental meetings and 'hot topics' meetings.</li> </ul>

## 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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>We saw that the practice had an arrangement of policies including: chaperone policy, clinical governance policy and staff development plan.</li> <li>We saw that the business plan had included departmental and management responsibility, including specific duties for lead areas for example safeguarding lead, nurse lead and patient liaison officer.</li> <li>We saw evidence of regular governance meeting sessions and they were well attended.</li> </ul>	

## Managing risks, issues and performance

**There were effective processes for managing risks, issues and performance.**

	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.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>All staff were aware of where to access disciplinary, grievance and whistleblowing policies. There was a significant events policy, being open policy and blame free culture policy. Staff were able to describe how they would access these.</li> </ul>	

## 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice regularly monitored medicines alerts, prescribing safety recalls and the on-going monitoring of patient QOF exceptions. As part of the practice business planning we saw that patients were given the option to opt out of recall of exceptions towards the later part of the QOF reporting year which allowed an opportunistic review for patients.</li> </ul>	

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

### Any additional evidence

- We spoke with members of the current PPG and they told us that although it was sometimes difficult to contact the practice by telephone, prebookable appointments were available 2 weeks in advance. We were also told that there was recent new property build in the local area however, the practice undertook a review of the extra pressures on the service and this was reflected in their business plan.
- PPG members told us that the provider had committed to undertake suggestions and ways to improve access at a recent meeting in August and November 2022. The provider had committed to implement a new cloud based telephony system in early January 2023. PPG members also told us that they were planning to meet in March 2023 to review the implementation and progress of the new system in respect of what improvements the system had delivered.
- PPG members provided positive feedback about the responsiveness of the practice. For example, it was explained that the communication about access to appointments being changed to 2 week pre-bookable appointments had not been communicated effectively and the provider implemented a social media page to engage with local businesses to promote the message regarding bookable appointments.
- The PPG was seeking different ways to increase their membership of 8 members to a larger group utilising a mix of face to face meetings and video sessions.



## 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

### Examples of continuous learning and improvement

- The practice routinely carried out clinical audit and carried out quality improvement initiatives to drive improvement. For example, the practice completed a review of the care of people with a learning disability. This was completed using new clinical software which improved the recognition and recall of patients on the learning disability register. Patients that 'did not attend' were offered a specially arranged appointment and visited care homes for learning disability patients.
- The practice had developed an 'access and capacity action plan' which identified a number of actions to increase access and overall experience for patients. For example, increased staffing in reception, change in the telephony provider and collaboration with the ICB to seek ways of improving appointment availability.
- The practice was a part of a local Primary Care Network (Billingham and Norton Primary Care Network) to support the delivery of national service specifications and consider and develop a wider range of services and to more easily integrate with the wider health and care system.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

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