

Care Quality Commission

Inspection Evidence Table

Coleridge Medical Centre (1-550789003)

Inspection date:

21st April 2023 (remote searches)

25th April 2023 (on site)

Date of data download: 21 April 2023

Overall rating: Good

Safe

Rating: Good

Although we rated safe as good there were the following areas where the practice should continue to make improvements

- The practice should ensure MHRA Alerts were actioned in a timely manner.
- Patient record summarising should be completed within a reasonable timescale.
- The practice should replace carpet tiles with solid flooring in clinical areas.
- Computers with clinical software in use should be locked when not in use.
- Patient facing staff must be trained to appropriate levels in safeguarding.

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.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice has a safeguarding lead, and all staff were aware of what to do with a safeguarding query.</p> <p>Adult safeguarding training was not in line with current national guidelines. The Adult Safeguarding: Roles and Competencies for Health Care Staff August 2018, states that safeguarding vulnerable adults training level 3 should be undertaken by registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role). Training records demonstrated that all staff were trained to Level 1 Adult safeguarding, however only 6 of the 10 nursing team members had up to date level 2 Adult safeguarding and all the GP's level 2 adult training was out of date.</p> <p>Children's safeguarding training was not in line with current national guidelines. The Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, January 2019 states that safeguarding vulnerable children level 3 training is required for all clinical staff working with children, young people, parents and carers of children. This includes general practitioners and registered nurses. All staff were trained to level 1 children safeguarding, all nurses, health care assistants and pharmacists had Level 2 Children safeguarding and all GPs had completed Level 3 Children Safeguarding. However, they should consider all staff being trained to Level 2 and all clinicians including healthcare assistants being trained to level 3 safeguarding.</p>	

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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 15 th November 2022 Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: Health, safety and fire systems were monitored to promote patient and staff safety. We observed the premises were fire tested by an external company annually. The practice had allocated fire wardens and fire drills were undertaken weekly and were used as a training exercise. Emergency lighting was checked weekly. We observed the premises and equipment was registered and monitored on an asset log, servicing of premises and equipment was monitored to ensure that all annual checks were completed.	

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.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 24 th January 2023	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The practice had an infection prevention and control lead, updated policies and procedures for staff to reference and regular audits to ensure good IPC practice. We observed washable carpet tiles in clinical areas which could be cleaned with soap and water, and damaged tiles could be removed and replaced. The management recognised that while this was sufficient it was not ideal. Audits demonstrated that carpets being replaced in consultation rooms were highlighted as a priority.	

Risks to patients

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

	Y/N/Partial
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There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We observed that there was information around the building to inform staff of what urgent action to take if a patient deteriorated. Staff told us they could call for help and also raise an alarm by telephone.</p> <p>The emergency trolley was well equipped and checked weekly. We observed equipment was available for medical emergencies including anaphylaxis and sepsis. Anaphylaxis is a severe and potentially life-threatening reaction to a trigger such as an allergic reaction. Sepsis is the body's extreme response to an infection and is a medical emergency. Learning from previous incidents had been used to develop the systems in place for emergencies. For example, grab boxes were now available for anaphylaxis and sepsis, so that patients could be treated wherever they were in the building.</p> <p>We observed the practice had implemented a customised electronic system to support reception and call taking staff with initial decision making and priority of treatment and signposting to patient care. This enabled staff to tap the screen where appropriate for patient symptoms raised. For example, if a patient had a headache, they could access an agreed set of actions for that staff member to provide information, refer to the GP, or signpost to other services. Children had a different set of signposts to adults and emergency action was highlighted for all children and adults. In all cases there was access to a GP if staff had any queries or concerns. This system provided a tailored approach for staff to follow and therefore provided a standardised process. This had been in use for 3 months. Staff told us they were pleased with the system and felt it supported their practice.</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. ¹	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes

There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We observed robust administrative systems which ensured appropriate clinical input were in place around referrals and test results, However, we identified that the practice has over a year backlog in summarising patient records. Summarising is the process of looking at patients records and extracting an accurate medical history in chronological order. We observed that a system was in place to ensure the high-risk and vulnerable patients were summarised first to promote patient safety.</p> <p>The practice was in the process of employing a new staff member to support this role and address the backlog.</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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	0.80	0.82	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2021 to 30/09/2022) (NHSBSA)	7.1%	8.8%	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 (01/04/2022 to 30/09/2022) (NHSBSA)	5.34	5.70	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	75.3‰	139.5‰	129.6‰	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.44	0.70	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	4.4‰	7.3‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹	Yes
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.	Yes
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. ²	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes

Medicines management	Y/N/Partial
Vaccines were appropriately stored, monitored, and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>We observed paper prescriptions were stored securely and audited to ensure safe management. However, one consultation room had a printer draw that could not be locked. This meant that staff could not tell if any prescriptions were missing. Management took immediate action to ensure that the printer drawer which could not be locked was replaced. During the onsite inspection management checked all other printers were secure.</p> <p>As part of the inspection clinical record searches were undertaken by a Care Quality Commission (CQC) GP specialist advisor (SpA) without visiting the practice. The following results were identified:</p> <ul style="list-style-type: none"> Disease modifying anti rheumatic drug (DMARDs) medicines used to treat autoimmune conditions were being completed by secondary care and this had not been coded appropriately and therefore incorrectly reported reviews were overdue. <p>The Cockcroft Gault creatinine clearance calculation (test for kidney function) had not been recorded at the time of adding the drugs to the repeat template, therefore, this was potentially incorrectly showing an overdue alert if the tests had been done and not recorded at a different time. The drug dosing was correct. This meant there was a risk that patients may not be seen and reviewed when they should be.</p>	

Track record on safety and lessons learned and improvements made.

The practice learned and made improvements when things went wrong/did not have 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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	36
Number of events that required action: (of 36 events 6 were major, all investigated and actioned)	36
<p>Explanation of any answers and additional evidence:</p> <p>There were clear systems for identifying and recording significant events, the practice demonstrated actions and learning associated with these. The lead GP oversaw events and looked at the root cause analysis to promote learning and safe practice.</p>	

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

Event	Specific action taken
A patient had been triaged and marked urgent and added to visit screen early in the day, the duty doctor completed a full day of calls and other visits, but no one picked this visit up despite there being other doctors available.	The case was reviewed along with other failures to visit. The conclusion was that as all visits were now triaged this can delay by several hours the patient visit and Dr's were out of the habit of picking up visits due to drop in number over the Covid period, therefore there was an assumption that other Dr's would pick up the call. Action taken - Visit requests were now actively managed and allocated to individual clinicians.
A clinician had been allocated 2 urgent same day patients by the afternoon triage phone clinic, where the patient had called in morning with chest pain. (Patients had been advised to call 999 if worsening).	Clinician raised this at the significant event meeting. The practice reconsidered the chest pain treatment pathway, offering education to the administration team, to ensure that all patients with chest pain were triaged and screened via video call early in day. (Patients had been advised to call 999 if worsening). Within the nurse practitioner appointments, there were now protected face to face slots.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: As part of the remote inspection, we observed the practice were slow to initiate the review of the medicines and healthcare products regulatory agency (MHRA) alerts. For example, alerts referring to the drugs Pregabalin and Topiramate which had been issued in April 2022 and July 2022 respectively had not been actioned until January/February 2023. The practice told us this has been down to lack of pharmacy support, and this was now resolved.	

Effective

Rating: Good

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

Although we rated effective as good there were the following areas where the practice should continue to make improvements.

- Patients with learning disabilities did not always have an annual health check.
- Patients having had more than one course of emergency steroids for asthma did not always have appropriate follow up reviews.
- The practice uptake rate for cervical screening for eligible patients was slightly under the national minimum requirement.
- The practice should ensure a consistent recording quality of medication reviews.

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. ³	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes

Effective care for the practice population

Findings

- 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 where abnormalities or risk factors were identified.

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder achieving annual reviews of over 95%.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- Patients with learning disabilities did not always receive an annual health check in the last 12 months only 52% of patients were reviewed.
- The community urgent care response team would go out to a patient on the same day on request to support hospital admission avoidance.

Management of people with long term conditions

Findings

The practice recalls patient for reviews in line with their birthday, if the patients did not initially respond a further 2 requests were sent out. All reviews included a medicines review which were completed by a nurse and clinical pharmacist.

Our remote searches showed that some patient reviews were overdue, for example,

- Patients with asthma who required 2 or more courses of rescue steroids did not always have an annual review to ensure their care and treatment was effective. We identified that of the 1450 patients on the surgery asthma register, 135 had 2 or more courses of emergency steroids within the last 12 months, we reviewed 5 records and 2 were overdue an asthma review. We found that 340 patients potentially required a steroid treatment card. Whilst the inspection was ongoing the practice started to distribute these.
- We reviewed patients with a range of long-term conditions for example, hypothyroidism, chronic kidney disease stages 4 or 5 and diabetic retinopathy and found a varied quality within the documentation of the medication review which was potentially down to training on the clinical reporting system.

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)	123	127	96.9%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation	123	129	95.3%	Met 95% WHO based target

for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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)	123	129	95.3%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	125	129	96.9%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	155	161	96.3%	Met 95% WHO based target

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

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	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)	72.8%	66.5%	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)	77.2%	71.5%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	60.3%	58.0%	54.9%	No statistical variation

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

Any additional evidence or comments
The practices cervical cancer screening uptake was 78.3% which did not meet the national minimum target of 80%.

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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

Audits were being used to review the service being provided and create prioritised action plans and ongoing monitoring to improve the service. We reviewed many examples of completed audits carried out by the practice for example:

- Bowel Cancer Audit - August 22
 - Combined oral contraceptive pill in women over 51 years old.
 - High intensity statins use.
 - High risk drug monitoring to review prescribing and usage.
 - Infection prevention and control (IPC) audits had taken place on 24th January 2023 using an infection prevention and control audit tool of compliance for general practice. A hand hygiene had been completed.
 - Safe management of care environment and safe management of care equipment was also completed in April 2023. An action plan drawn up which highlighted:
 - Guidelines and policies to be updated around curtains, carpets and clutter in clinical areas as well as handwash facilities in clinical areas needed addressing.
 - Cleaning standards to be addressed.
 - Need to declutter.
- All highlighted concerns were taken to the next appropriate meeting and quotes were being sourced where appropriate.
- The practice infection control and premises maintenance plan prioritised replacing carpets with hard floor, the removal of curtains from treatment room fixtures and fittings.

Any additional evidence or comments

The nursing team had developed a wound care and lower leg ulcer pathway including onward referral to local community services. This included auditing patient wounds from first presentation to full assessment. The audit outcomes was fed into the specific leg ulcer clinic within 2 weeks of full assessment and also to the tissue viability team. Staff told us that since its commencement in 2019, this had shown significant improvements in patient outcomes including healing rates.

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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Coordinating care and treatment

Staff worked/ did not work 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.	Yes
Patients received consistent, coordinated, person-centered care when they moved between services.	Yes

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Any additional evidence or comments

The practice told us they worked closely with local community projects including Ottery Health Matters and Ottery Health Scheme and could signpost patients through these schemes to projects such as Mens Shed, Youth Mental Health service and a food larder. Ottery health matters focus on health promotion, the medical staff at the practice were active within the group to provide health information for the public of Ottery. For example, a dementia day was implemented, and the service provided input as well as the doctors giving talks on dementia within the community.

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Yes

Caring

Rating: Good

Kindness, respect and compassion

**Staff treated/ did not treat patients with kindness, respect and compassion.
Feedback from patients was positive/ negative about the way staff treated people.**

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

Patient feedback	
Source	Feedback
Friends and family feedback March 2023	Patients responded to "Thinking about your recent appointment, how was your experience with our service" as follows: 83% Very good and 13.6% Good,
NHS Choices	There was only 1 review in total for this practice on the website which had rated the surgery 5 out of 5

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	86.9%	89.1%	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)	86.7%	89.1%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	95.5%	95.4%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	75.5%	79.6%	72.4%	No statistical variation

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

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: The practice has 2 carer leads who work with the support of the Ottery Help Scheme to support carers of patients. As part of Ottery Health Matters, the surgery supports themes such as breast cancer and carers support. The practice has a nurse who leads for patients with learning disabilities. Easy read and pictorial posters and leaflets were available, and the surgery had introduced blue book health action plans which allowed the patient to share their likes and dislikes around being seen by a clinician and the clinician adds the appointment outcomes and discussion to allow the patient to share with carers or family if they choose.	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	89.0%	93.3%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a hearing loop available for those patients hard of hearing. Hearing Loop is an audio system connected to an amplifier to aid patients to hear. Deafness awareness training was being rolled out to support staff to have a wider understanding of the subject.</p> <p>Language line was available for patients who did have English as a first language, and staff gave us examples of its recent use and staff could contact a sign language service if it was required.</p> <p>Leaflets were available throughout the practice and reception staff could access those leaflets in large print and Braille.</p>	

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.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence:	
<p>The practice provides medical support for local nursing homes and works closely with the community teams, this includes a learning disability service. The primary care network (PCN) had a care homes coordinator who liaised with the practice and the nursing homes as needed. The safeguarding lead for the practice was involved with the nursing home when there was a safeguarding need and annual reviews were undertaken by an identified team from the practice.</p> <p>The practice had access to occupational therapists, physiotherapists, staff providing mental health support and social prescribers.</p> <p>As part of working in the community with accessible groups, the practice was able to sign post to appropriate support for example veterans' groups, homeless groups, learning disability support groups and dementia care support groups.</p>	

Practice Opening Times

Day	Time
Opening times:	
Monday	0800-18.30
Tuesday	0800-18.30
Wednesday	0800-18.30
Thursday	0800-18.30
Friday	0800-18.30

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

The practice opening hours can be extended to later in the evening on an appointment basis, following telephone triage.

- The practice online consult system offers an alternative way to self-help and contact 24/7 (response was within the working day).
- The surgery offers extended hours as part of the federation (13 practices in East Devon) there was a rota system where 2 practices open to cover the evenings, Saturdays and Sundays.
- The practice on occasions offers specialist clinics at weekends i.e., Cervical smear testing clinics or minor operation clinics.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- The practice nurses proactively offer outreach clinics to the travelling community and discuss any health needs with individuals generally whilst on site.

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	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes

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)	42.5%	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)	52.7%	64.7%	56.2%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
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)	38.8%	62.6%	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)	69.2%	79.7%	71.9%	No statistical variation

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care/ Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	38
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: Patients were contacted by the Lead GP as a result of a complaint, this was followed up in writing. Staff told us that complaints and concerns go through the same process as significant events, being investigated, and reviewed and discussed at the monthly significant event meeting. Complaints were also shared with individuals as appropriate, and anonymised updates were added on the internal private platform holding material relevant to the provider. Learning was discussed and shared across the primary care network (PCN).	

Example(s) of learning from complaints.

Complaint	Specific action taken
Action not taken after receipt of a significant abnormal test result	The complaint was reviewed and upheld, a letter was sent to the complainant. The learning outcome required the correspondence protocol to be reviewed and updated, ensuring admin staff highlight abnormal results to a GP.

A deteriorating child waited 3.5 hours for a triage call back.	The learning outcome was an improvement made to the data available on the on-call appointment screen, so the triaging doctor can identify patients that need contacting more urgently.
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Well-led

Rating: 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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	
The practice has 4 full time partners and 10 salaried GPs. Succession planning was ongoing.	
The practice identified recruiting and training staff as a challenge and had taken on a “grow your own” approach and was therefore developing registrars and student nurses, with the hope of long-term staff retention.	
Staff told us that the practice offered staff opportunities to develop and supported staff in training to develop extra specialty roles. The practice had recently successfully recruited and trained 2 GP assistants from internal staff. This is a support role carrying out administrative tasks combined in some areas with basic clinical duties.	

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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence:	

The practice values and strategy were evident to staff. The values were printed on lanyards worn by staff and we're also used as part of the interview and induction process.

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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
Management told us that well-being was at the forefront of the practice's thinking, and they had specifically employed a wellbeing & workforce development supervisor. This staff member had trained as a mental health first aider, and the role included promoting the wellbeing benefits the surgery offered and collating the annual staff survey. This survey had an upward trajectory year on year and was used to support staff wellbeing.	

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

Source	Feedback
CQC staff feedback survey	19 forms had been completed all commented around there being a good supportive team.

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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Explanation of any answers and additional evidence:	

Each of the 4 partners was allocated a management responsibility for a team and specific areas of responsibility within the practice. These teams were organised into buddy groups to ensure resilience and support, each having clear lines of management.

The practice held twice weekly huddles to ensure all information was communicated and to allow for any questions. There was also regular staff, clinician and significant events meetings being held to ensure shared learning and promote and develop the practice.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: The practice governance systems were comprehensive and frequently reviewed and well communicated. This included the risk register, the contingency plans and staffing and recruitment information.	

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: The surgery had introduced an application-based system for their reception and telephony staff to support them in making consistent decisions around prioritising patient needs, test results, and sign posting patients to an appropriate internal or external service. The surgery had set up bespoke parameters within the software and had separate algorithms for adult and child conditions. In all cases there was access to a GP if staff had any queries or concerns. This system provided a tailored approach for staff to follow and therefore provided a standardised process. This had been in use for 3 months. Staff told us they were pleased with the system and felt it supported their practice.	

To support access to the services there was a patient partner system. This was a 24-hour automated service which enabled patients to book or change appointments on the telephone. For patients who did not want to do this, the system could be bypassed to allow access to a receptionist during working hours. Calls were audited and the log produced was used to align the times of higher demand to the staffing rota. The call audits also monitored abandoned calls, calls were recorded and used for training, some calls were used to support staff learning as well as to develop the services already there. An example was a debrief of a challenging conversation to support management of similar calls in the future.

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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Partial
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence:	
Patient records were held digitally and in paper format and were both stored securely. However, we noted that one consultation room was unlocked, and the electronic records were not secure. Staff recognised this was an error and took the appropriate action to ensure patients record security.	
Disposal of confidential information was managed by secure shredding.	

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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
The practice was developing champion lead roles. For example, learning disability champions and recruitment champions. These champions were to promote these areas within the practice but also be accessible to external stakeholders.	

Friends and family survey current data showed 90 - 95% of information received was positive. When comments were received any staff identified with positive comments were applauded.

Suggestion boxes were noted around the building and included suggestion boxes for staff comments. The practice used Teamnet (an electronic platform) for staff feedback, and they used the announcement page of Teamnet as a staff weekly newsletter. Twice weekly staff huddles were also used to gather and disseminate information.

The practice worked closely with community voluntary groups including Ottery Health Matters.

The practice had a virtual Patient Participation Group which currently had around 180 members (they initially started with around 20), of which 56% were under the age of 55. Recruitment has been via social media and the practice website. The practice used the group to get quick feedback and put out surveys which take no longer than 5 minutes to complete on various aspects of the practice. The initial survey was around mental health, and the practice were currently working on having virtual panels for different topics.

Feedback from Patient Participation Group.

Feedback
The groups initial survey was about mental health. They received feedback and were reviewing the subject of community exercise with the support of social prescribers and Ottery Health matters.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
Coleridge Medical Centre was awarded the University of Exeter, College of Medicine and Health's 'Excellence and Innovation in Clinical Teaching Team Award for GP Practices' (2021/2022).	

Examples of continuous learning and improvement

The practice has moved forward with technology to improve the way it worked using:

- The 24-hour access telephone service and portal.
- Application software to ensure breadth of access options for telephony and reception staff to offer to patients.
- Cloud based telephony software to support understanding of times of demand.
- The practice disaster recovery contingency plans were reliant on their telephony having cloud technology.
- The use of social media to disseminate information and use of the virtual Patient Participation Group to gather information quickly for a broad demographic of patients.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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