

Care Quality Commission

Inspection Evidence Table

Church Lane - Khan (1-537760126)

Inspection date: 5 September 2022

Date of data download: 04 August 2022

Overall rating: Requires Improvement

At our previous inspection in May 2021 we rated the service as Requires Improvement overall due to concerns relating to the governance arrangements, medicines management and effective management of some clinical indicators. At this inspection we continued to rate the practice as Requires Improvement overall. The practice had faced significant staffing and leadership challenges over the last 12 months which had delayed progress, as well as issues relating to the premises. The practice was now in a better position that some of these challenges had been addressed and had the leadership needed in place. While we saw some improvements had been made, most of these were relatively recent and needed to be embedded.

Safe

Rating: Requires Improvement

At our previous inspection in May 2021 we rated the practice as Requires Improvement for providing safe services as improvements were required in the management of medicines and environmental risks. At this inspection the practice continues to be rated as requires improvement, the staffing shortfalls, until recently, had hindered any significant progress. Now that staffing had improved, the new practice manager was working to implement and embed systems and processes to support safe services. Decisions in relation to the future of the premises had also not yet been confirmed limiting some of the progress in fully addressing the environment. We also found learning from incidents and managing safety alerts needed strengthening.

Safety systems and processes

The practice systems, practices and processes to keep people safe and safeguarded from abuse were being re-established following an absence of clear practice leadership.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had been without clear leadership for approximately six months at the start of the 2022. This had impacted on the systems for safeguarding and over the last year we saw that there had only been one safeguarding meeting. A new practice manager was appointed in May 2022 and was starting to re-establish those systems, this included a review and updating of safeguarding policies and re-establishment of safeguarding meetings. At our previous inspection we identified that some clinical staff were not up to date with the providers mandatory safeguarding training requirements to an appropriate level and that there was a lack of effective systems for monitoring this. At this inspection we found all staff were up to date with safeguarding training for children and adults and that this was to an appropriate level for their roles and responsibilities. The practice had a safeguarding clinical lead and an administrative lead. Staff we spoke with were aware of the processes in place if they had a safeguarding concern. We saw from our clinical records review alerts were placed on the system; this included any other family members so that staff were aware of anyone at risk of harm 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed recruitment records for two recently employed staff and found appropriate staff checks in place. We reviewed staff immunisation records for four clinical members of staff and found records had been maintained. Non-clinical staff we spoke with told us that they were also required to provide evidence of their staff immunisation status. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 16 August 2022	Partial
There was a fire procedure.	Y

Date of fire risk assessment: 16 August 2022	Partial
Actions from fire risk assessment were identified and completed.	
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The premises although clean and tidy were in need of refurbishment. The principal lead GP was looking to take over the premises from the current landlord and an external health and safety and fire risk assessment had been undertaken to identify actions needed. We saw that actions from the risk assessments were in progress and a longer-term refurbishment plan in place once there was certainty over the premises. At our previous inspection in May 2021 we found that corridors leading to consulting and treatment rooms were narrow and the fire safety for patients who were unable to evacuate the premises on their own had not been considered as part of the practice's fire risk assessment and no disability access audit was available. Development of Personal Emergency Evacuation Plans (PEEPs) had also not been developed. At this inspection we found no evidence that these concerns had been actioned. Following the inspection, the practice updated their fire risk policy to include a PEEPs template to be completed with relevant individuals. However, the fire risk policy was not practice specific in stating how it would support patients with mobility difficulties in the event of a fire. We saw records which showed equipment including fire safety equipment had been tested and that staff had received fire safety training. Clinical equipment had undergone calibration checks and portable appliance testing to ensure they were safe and in working order. We found safety risk assessments for the Control of Substances Hazardous to Health (COSHH) however, we found storage of COSHH was not secure from potentially unauthorised access. Following the inspection the practice forwarded photographic evidence that they had moved COSHH products to a secure place within the practice. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met although the premises were in need of some refurbishment.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: July 2022	
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had been without a practice nurse and practice manager for several months during 2022 leading to a delay in undertaking an infection prevention and control (IPC) audit. We saw from the action plan and our observations of the practice that some of the actions had been put in place and those relating to wider refurbishment had been added to the practice's longer term plan, once there was more certainty with the premises. We saw appropriate arrangement for the safe removal of clinical waste. 	

- Reception staff we spoke with were able to tell us systems in place for the safe handling of specimens.
- Training records showed all staff had completed IPC training and had access to a range of IPC policies for support. Spillage kits were in place for the safe cleaning of bodily fluids.

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	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Over the last year the practice had struggled with staffing both clinical and managerial with most of the vacancies now filled. We saw that staff rotas were in place for the non-clinical team who told us that they covered each other during absences. • Training records showed that staff were up to date with Basic Life Support training and had undertaken sepsis training. Emergency equipment and medicines were available and staff knew where these were stored when needed. Where recommended emergency medicines were not routinely stocked, the practice had in place risk assessments which outlined the rationale and mitigation of risk for this. 	

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.	Partial
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">• Our review of clinical records found patient information, including the review of test results were dealt with in a timely manner by clinical staff.• A sample of referral letters seen for specialist services contained relevant information.• The practice had established systems for monitoring two week wait referrals to ensure patients were seen.• Staff advised that there was currently a backlog of summarising new patient records, these were currently managed by the principal GP but there were plans to train a member of staff to take over this role.	

Appropriate and safe use of medicines

The practice had systems to support the appropriate and safe use of medicines, including medicines optimization however, there were areas for improvement identified.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.87	0.79	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	7.3%	8.1%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	4.69	5.19	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	229.0‰	113.4‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	1.13	0.62	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	11.5‰	7.7‰	6.8‰	Tending towards variation (negative)

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

Medicines management	Y/N/Partial
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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> During our inspection we reviewed the management of a sample of patients on Disease-modifying antirheumatic drugs (DMARDs) and other high-risk medicines which require regular monitoring and blood tests due to the risk of serious side effects. We found patients on these medicines were generally well managed and all records reviewed had received appropriate blood tests. For example, no patients on the three Disease-modifying antirheumatic drugs (DMARDs) we reviewed were overdue their monitoring. DMARDs are commonly used to treat rheumatoid arthritis. There were no patients overdue their monitoring for a mood stabilising medicine and relatively few patients on ACE inhibitors and Angiotensin II receptor blockers were overdue. However, we did identify some areas for improvement, this included recording the day of the week to take a Disease-modifying antirheumatic drugs (DMARDs) in line with guidance to minimise the risk of overdose and routine issuing of steroid cards for patients who have been issued more than two rescue steroids in the last 12 months. We also found that 95% of patients on a Direct Oral Anticoagulant (DOAC) used to reduce the risk of blood clots were up to date with monitoring, however in the five patients we reviewed we 	

Medicines management	Y/N/Partial
<p>found the measurement of heights and weights to calculate creatinine clearance were not up to date to ensure the correct dosage of the medicine continued to be given.</p> <ul style="list-style-type: none"> • At our previous inspection in May 2021 we found that patients on high risk medicines did not have the reason for prescribing coded and would therefore not be picked up on the clinical searches. At this inspection we found reasons for prescribing had been recorded. • The practice was supported by a pharmacist who was also an independent prescriber one day per week through Primary Care Network arrangements. The pharmacist advised that they worked alongside the clinician who provided support as needed although there were no formal audits of their prescribing practice undertaken of their work. • National prescribing data showed practice prescribing was in line with local and national averages in most categories. There were some higher prescribing areas including multiple psychotropics, hypnotics, pregabalin and gabapentin, staff advised this was largely due to the practice population but told us they were working to reduce prescribing in these areas. • The practice shared with us antibiotic prescribing audits undertaken by the CCG. These showed improvements in antibiotic prescribing at the practice. • Our review of the clinical system found that 87% of patients on four or more medicines had received a medicines review in the last 12 months. This was higher for patients over the age of 65 years at 93%. 	

Track record on safety and lessons learned and improvements made

There was limited evidence of systems 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.	Partial
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.	Partial
Number of events recorded in last 12 months:	1
Number of events that required action:	1
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found limited reporting and learning from incidents. The current practice manager had been in place for three months and was only aware of one reported incident from March 2022 which had occurred prior to their employment. The incident had only recently been reviewed at a practice meeting to support learning and improvement. Staff we spoke with were aware of the systems in place for reporting incidents and sharing any learning. We saw that incidents were now a standing agenda item on the practice meetings which had recently been reinstated by the new practice manager. 	

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

Event	Specific action taken
Patient discharge letter filed without it being seen by the GP or acted upon.	The incident was reflected upon by those involved and discussed at a team meeting.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At our previous inspection in May 2022 we found that safety alert recommendations were not always actioned. At this inspection we found that this was still an area the practice needed to improve. As part of our clinical searches we reviewed action taken by the practice in response to two Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts. One of the MHRA alerts from 2018, related to a medicine that has the potential for increasing the risk of skin cancer, of the four patients who had been on this medicine there was no evidence that the risks had been discussed with them. 	

- The practice manager explained that alerts were placed onto the shared computer system to be discussed at practice meetings and shared with us a policy for the management of incident, they were not aware of any that had needed to be acted on since they had been employed.

Effective

Rating: Requires Improvement

At our previous the inspection the practice was rated as requires improvement for providing effective services due to a lack of compliance with evidence-based practice for prescribing, poor uptake of national screening and childhood immunisations and low performance against the Quality Outcomes Framework for long term conditions. At this inspection, the practice demonstrated improvements in prescribing and management of long-term conditions, trends in childhood immunisations and cervical screening uptake were improving, although further work was still required to meet minimum targets in these areas. However, we continue to rate the practice as requires improvement for effective due to the lack of clear evidence to demonstrate competencies in staff with advanced or extended roles, there was also limited evidence that patients end of life wishes were routinely discussed, where appropriate.

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 mainly 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.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Clinical staff told us that they tried to keep up to date in their clinical practice through local networks and forums. They had access to evidence-based guidance such as those from the National Institute for Health and Care Excellence (NICE). 	

- The practice made use of templates when providing care and treatment to ensure a consistency of approach and ensure things were not missed.
- We found appropriate management of patients' medicines and long-term conditions during our clinical reviews was largely in place. However, we identified safety alerts were not always managed in line with recommendations.

Effective care for the practice population

Findings

- Practice staff were unable to confirm how they identified older patients who were living with moderate or severe frailty. However, they told us that there was a palliative care register for their vulnerable older patients.
- 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.
- The practice was able to provide eligible patients with the meningitis vaccine, for example before attending university for the first time, on request.
- 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. The practice advised that 73 health checks were undertaken in the last year and hoped that with the recruitment of a permanent Healthcare assistant this would increase.
- All patients with a learning disability were offered an annual health check. The practice advised that during 2021/22 they had completed 40 learning disability health reviews, this equated to 89% of their learning disability register. Work was also being carried out to improve the accuracy of their register.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Patients on the palliative care register were discussed monthly.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. The practice was located close to a local provider who supported patients who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The practice had previously had low numbers of mental health reviews completed. At this inspection we found that most patients on the practice's mental health register (91%) had received a review in the last year and all patients on the dementia register had been reviewed.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- As part of our inspection we reviewed the management of patients with long term conditions and found from the sample reviewed, patients were generally well managed. This included:

Five patients with the potential for a missed diabetes diagnosis. We found four out of the five patients had been appropriately coded to ensure they were picked up for ongoing reviews and all had received an annual review to check their condition had not deteriorated. However, we did identify one patient where a repeat test was required in line with guidance and one patient whose blood results indicated diabetes but had not yet been followed up or coded as diabetic.

We reviewed records for five patients with poorly controlled asthma that had been issued two or more rescue steroids in the last 12 months. All had received appropriate follow up, however steroid cards had not been routinely issued, where appropriate.

There were two patients out of 90 with hypothyroidism who had not received monitoring in the last 18 months. In both cases the patients had failed to respond to recall for follow up.

No patients with late stage Chronic Kidney Disease were identified that had not received appropriate monitoring.

We reviewed five patients with poorly controlled diabetes all of which had received timely follow up and review of their condition.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- There was a schedule in place for calling patients with long term conditions in for their review. Long term condition reviews were largely carried out by the GPs.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered appropriate medicines.
- Patients with suspected hypertension were asked to undertake home blood pressure monitoring and share recordings with the practice.
- 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%
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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)	37	42	88.1%	Below 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)	36	39	92.3%	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)	36	39	92.3%	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)	36	39	92.3%	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)	31	39	79.5%	Below 80% uptake

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>

Any additional evidence or comments

- The practice was meeting the minimum uptake target of 90% for childhood immunisations given at age two. This was an improvement on the previous year by approximately 5%. There was also an improvement in the childhood immunisation uptake for children at age five by approximately 3% however, this indicator was still below the minimum target of 90% and below the WHO target of 95% (the recommended standard for achieving herd immunity). Uptake of childhood immunisations at age one was just below the 90% minimum and had slightly declined from the previous year.
- The practice had been without a practice nurse for several months during the last year and had recently recruited a practice nurse whose focus was on child immunisations and cervical screening. Staff told us that they contacted the parents or guardians of children that did not attend for immunisations on three occasions and if they still did not turn up would send a letter to encourage attendance. The principal GP was informed of those that still failed to attend to decide on any action needed.

Cancer Indicators	Practice	CCG 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: 31/03/2022) (UK Health and Security Agency)	66.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	36.0%	52.8%	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)	52.8%	55.6%	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)	53.3%	52.9%	55.4%	No statistical variation

Any additional evidence or comments

- Since our previous inspection there had been a slight improvement in the uptake of cervical screening from 64.5% to 66.4%.
- The practice had been without a practice nurse for several months during the last year and had recently recruited a practice nurse whose focus was on child immunisations and cervical screening. Staff told us that they followed up non-attenders for cervical screening on three occasions and if they still did not attend they would send a letter to encourage attendance.

Monitoring care and treatment

The practice had undertaken some quality improvement activity and 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.	Partial
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

- There was some evidence of quality improvement initiatives including audit having taken place, but these had been limited due to the staffing challenges faced by the practice over the last 12 months.
- The practice shared with us two one cycle prescribing audits that had been completed by the PCN Pharmacist. They reviewed the prescribing of two disease-modifying antirheumatic drugs (DMARDs) in line with evidence-based guidance.
- The practice also participated in the CCG led antibiotic prescribing audits, this showed improvements in antibiotic prescribing at the practice.
- Practice staff told us that they were working to improve the learning disability register and ensure this was as accurate as possible. As a result, the register had increased from 45 to 80 patients

Effective staffing

The practice was able to demonstrate that staff in most cases 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.	Partial
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.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had identified mandatory training requirements for all staff and we saw that there had been good uptake from staff to complete this training.• We reviewed training records for staff undertaking extended roles for example, cervical screening and immunisations. One member of staff told us how they had been supported to undertake further training so that they could develop and carry out extended roles.• We saw evidence of supervision audits undertaken for the salaried GP and practice nurse. However, this was not evident for the pharmacist or healthcare assistants undertaking long term condition reviews to ensure their competence.• We saw evidence of induction processes for new staff and appraisals.	

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
Explanation of any answers and additional evidence:	

- The new practice manager had re-established multi-disciplinary meetings to discuss some of the practice's most vulnerable patients following staffing struggles. Health and care staff working in the community were invited to these meetings.

Helping patients to live healthier lives

Staff were 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Patients were able to access NHS health checks, and vaccination programmes as relevant.• Patients at risk of developing diabetes were referred to the national diabetes prevention programme.• The practice provided inhouse support for weight management.• Through the Primary Care Network (PCN), the practice had recently introduced several new initiatives offering lifestyle support programmes to their patients, this included a diabetic outreach programme and a programme to support younger women with depression and weight concerns.• The practice also had plans to install a health kiosk at the practice from October 2022 to promote awareness of heart diseases. Patients would be able to check their weight and blood pressure and share this with the practice.	

Consent to care and treatment

The practice 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.	Partial
Explanation of any answers and additional evidence:	

- Staff had access to consent policies including those relating to the Mental Capacity Act. We saw that clinical staff had undertaken and were up to date with Mental Capacity Act training.
- There was a consent form for minor surgery although the practice advised that they had not carried out any minor surgery at the practice since the pandemic.
- As part of the inspection we reviewed a sample of three DNACPR decisions. Those seen were all specific to the local hospital and were only relevant to the time of their stay in hospital with the expectation that they were reviewed by the GP on discharge. This had not yet been completed by the practice.

Well-led

Rating: Requires Improvement

At our previous inspection in May 2021 we rated the practice as requires improvement for providing services that were well led, this was due to improvements needed in the governance for areas such as safeguarding, safety alerts, effective management of risk and performance. At this inspection we continued to rate the practice as requires improvement in this key question. The practice had been through a particularly challenging time with long periods without leadership and shortfalls in clinical staffing, while progress was being made to improve staffing and develop stronger governance the arrangement recently put in place needed to be embedded.

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">The practice had been through a difficult and challenging time during the last year, having been several months without a practice manager and practice nurse. There had also been a shortfall in GPs. Most of the shortfalls had been filled and the practice was now in a better position to drive high quality sustainable care.Staff we spoke with told us that the leadership of the practice was visible and approachable and appreciated the leadership the new practice manager had provided since taking post.	

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">The practice shared with us their three-year Business Plan which set out their vision for the future. Staff were aware of the plan which was consistent with what we were told during our inspection.	

It took into account staffing, work life balance, the future of the premises and promoting patient health and wellbeing.

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.	N
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff told us that they had been through a challenging time but had supported each other as a team to ensure patients continued to receive the care and service they needed. The practice's business plan focused on supporting staff work life balance and recruitment of staff was helping to address this. Staff were positive about the new leadership and felt able to raise concerns, if needed. The practice manager advised that they did not currently have a named Freedom to Speak up Guardian but were working to identify someone for the role. Staff told us that they would approach the principal GP or practice manager if they needed to raise anything. Staff training records showed staff had completed and were up to date with Equality and Diversity training. 	

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

Source	Feedback
Staff interviews	Staff told us that the practice team were very supportive of each other which had enabled them to get through some of the challenging times. They welcomed the new practice manager in providing leadership and direction for the practice. Staff found both the managerial and clinical leadership approachable and supportive.

Governance arrangements

We saw improvements in governance arrangements since our previous inspection. However, further work was needed to embed effective governance within the practice.

	Y/N/Partial
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There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our last inspection in May 2021 we found areas in which governance arrangements needed strengthening. This included gaps in the employee immunisation checks, follow up of patients in line with practice prescribing protocols and high-risk patients, management of safety alerts and patient outcomes relating to the Quality Outcome Framework (QOF). At this inspection we found areas of improvement in relation staff immunisation checks, prescribing of patients on high risk medicines and patient outcomes. However, further work was needed to improve the management of safety alerts to ensure action was taken and maintained; for the strengthening of quality improvement systems in particular full cycle audits to demonstrate improvement; and systems for ensuring the competence of all staff in advanced and extended roles. Now that staffing was improving the practice was in a better position to address and continue to improve governance arrangements. The practice manager had reintroduced regular practice meetings to support the governance of the practice. Policies and procedures had been reviewed and were available to staff and staff told us that they felt their roles and responsibilities were clear. 	

Managing risks, issues and performance

The practice had been through challenging times and were working to ensure 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.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our inspection in May 2021, we found a lack of evacuation plan and fire risk assessment for patients with a disability. At this inspection we found that this could not be demonstrated however, following the inspection an updated fire safety policy was submitted which included a template for a personal emergency evacuation plan to be completed with patients who may not be able to leave the premises in an emergency unaided. At our inspection in May 2021 we found a lack of effective approach for managing long term conditions. At this inspection we found evidence of a recall schedule in place. Our clinical searches also demonstrated effective management of patients with long term conditions. At our inspection in May 2021 we found a lack of assurance in relation to the absence of recommended emergency medicines not routinely stocked should it be required. At this inspection we found risk assessments had been completed. During this inspection we identified risks in relation to the premises, the premises were in need of refurbishment and a lack of secure arrangements for the management of COSHH products. The provider was looking to take over the premises and in the interim a plan was maintained to manage refurbishment once this had been confirmed. We also received photographic evidence following the inspection that COSHH products had been moved to secure facilities. The recent reintroduction of practice meetings provided the forum for managing risks and performance. The practice had a Business Continuity Plan which set out the arrangements in the event of a disruption to the running of the service. 	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic.

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Additional infection prevention and control measures had been put in place to maintain staff and patient safety during the pandemic. • Patients we spoke with were positive about access and were able to obtain face to face appointments and home visits, if needed. Staff told us that additional clinics had been put in place to address any backlogs caused by the pandemic. • There was provision for staff to work remotely if needed but staff told us that clinical staff mostly worked onsite to see patients. 	

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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Staff were using data available to help address priorities.• We identified issues with the practice CQC registration that had not been addressed, the practice advised that they were working to rectify this.	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Staff had access to secure systems if they needed to work remotely but preferred to work onsite.• Patients had to register with identification in order to use online services.• The practice had recently introduced online requests using systems approved by their local Integrated Care Board.	

- The practice advised that they did not record phone calls with patients.
- Information governance was part of the practice's mandatory training and we saw from training records staff were up to date with this training.
- We saw evidence that the practice was registered with the Information Commissioners Office.

Engagement with patients, the public, staff and external partners

Due to staffing issues during the last year engagement with patients, staff and external partners to sustain high quality and sustainable care had been limited but was now improving.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The new practice manager had recently re-introduced a patient group and there had been one meeting to date with plans to meet on a regular basis going forward.• Results from the most recent GP National Patient Survey (published in July 2022) showed patients satisfaction with their experience and access to clinicians was generally in line with local and national averages.• At the last inspection we found a lack of evidence to demonstrate learning and action to improve the quality of care in response to complaints. At this inspection we found the practice was unable to provide much detail relating to complaints prior to the new manager taking post. However, we reviewed two recent complaints and saw that these had been investigated and responded to in a timely manner.• Staff had long periods without clear leadership during the last year, this was now improving with the reintroduction of practice meetings and appraisals in which staff could provide feedback.• The practice engaged with their local Primary Care Network; this is a group of local GP practices that work together to address local priorities.	

Feedback from Patient Participation Group.

Feedback
We spoke with four members of the practice's Patient Participation Group, they told us that they had only met once as a group but were happy with the service they received and access to the practice. They felt the meeting had been useful in helping them to understand the practice more fully and the services available.

Continuous improvement and innovation

The practice had been through a challenging time and needed to strengthen arrangements for learning and improvement. but were able to demonstrate some evidence of learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Circumstances relating to staffing had been difficult for those employed over the last 12 months who told us they had been delivering the service without guidance until recently. They felt as a team they had worked well and supported each other to ensure the continuity of services for patients. Patients we spoke with were very complimentary of the staff and how they had managed. • The practice had worked to address backlogs and we saw improvements in the learning disability register and in mental health reviews. • The practice had introduced a new website with online services which they hoped would help improve access for their patients. • Working with the Primary Care Network the practice told us about new services they could refer patients to relating to diabetes and mental health. They also had plans to introduce a health kiosk for patients to undertake health measurements such as blood pressure and weights and share those with the practice. • At our previous inspection in May 2021 the practice told us that they had been in engagement with the local Clinical Commissioning Group (now Integrated Care Board) over finding suitable premises and in relation to difficulties within the partnership. At this inspection the practice had worked to improve clinical staffing and had decided to remain in the current premises so that patients did not have to change, however this had raised further challenges over the refurbishment required for the premises. 	

Examples of continuous learning and improvement
<ul style="list-style-type: none"> • We saw some evidence of clinical audits; however, these were not full cycle audits and evidence was not presented in a way that clearly demonstrate improvements. However, we did see there had been some improvements in antibiotic prescribing within the CCG led audit. • The practice was only able to share recent and limited examples of learning from incidents and complaints due to the change in leadership.

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 CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

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