

Care Quality Commission

Inspection Evidence Table

Dashwood Medical Centre (1-2710506334)

Inspection date: 23 November 2022

Date of data download: 10 October 2022

Overall rating: Inadequate

We rated the practice as Inadequate overall because:

- The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.
- Appropriate standards of cleanliness and hygiene were not always met.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- Staff had some information they needed to deliver safe care and treatment. However, improvements were required.
- The practice had systems for the appropriate and safe use of medicines, including medicines optimisation, however improvements were needed.
- The practice did not have a robust system to learn and make improvements when things went wrong.
- Patients' needs were not always assessed, and care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- The practice was unable to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.
- The practice always obtained consent to care and treatment, however DNACPR decisions were not always made in line with legislation and guidance.
- Complaints were not used to improve the quality of care.
- There was compassionate and inclusive leadership, however improvements were needed to ensure the delivery of high-quality sustainable care.
- The practice had a culture which drove high quality sustainable care. However, the provider was unable to demonstrate they had an effective complaints procedure.
- There were some responsibilities and roles to support good governance and management. However, improvements were needed to systems of accountability for the management of backlogs of activity.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- There was little evidence of systems and processes for learning, continuous improvement and innovation.

Safe

Rating: Inadequate

We rated the practice as Inadequate for providing safe services because:

- The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.
- Appropriate standards of cleanliness and hygiene were not always met.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- Staff had some information they needed to deliver safe care and treatment. However, improvements were required.
- The practice had systems for the appropriate and safe use of medicines, including medicines optimisation, however improvements were needed.
- The practice did not have a robust system to learn and make improvements when things went wrong.

Safety systems and processes

The practice did not have 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.	No
Partners and staff were trained to appropriate levels for their role.	No
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.	No
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
Explanation of any answers and additional evidence:	
The practice had a designated safeguarding lead. Details of local safeguarding contacts were available throughout the practice. We asked to see the practice's safeguarding children and vulnerable adults policies, but these were not provided to us.	
We looked at the training records of 5 members of staff. Three staff members had received safeguarding training. However, there were no records to demonstrate 2 members of clinical staff had received safeguarding training at a level appropriate to their role. We asked the provider for evidence of this training; staff told us 1 member of staff was scheduled to complete this training in January 2023. The provider wrote to us and told us the other member of staff had completed this training in July 2022, however we were not provided with completion certificates to support this.	

Safeguarding	Y/N/Partial
<p>The practice had a safeguarding register. The practice's computer system alerted staff of children that were on the risk register. However, the system did not alert staff to family and other household members of children on the risk register. Staff told us they were aware of the requirement to add these alerts, we were told this had not been completed due to lack of staff. The provider told us an administrative safeguarding lead had been appointed in September 2022. The role of the administrative safeguarding lead included the addition of alerts to family and other household members of children on the risk register.</p>	
<p>There were notices around the practice and in clinical rooms advising patients that chaperones were available. There was a chaperone policy advising that any member of the practice team could act as a chaperone provided they had undertaken appropriate chaperone training. We asked to see evidence that staff members had received chaperone training. However, these training records were not provided to us. Therefore, we could not be sure staff who acted as chaperones had received the appropriate training.</p>	
<p>We asked to see evidence that staff had received Disclosure and Barring Service (DBS) checks (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We were not provided with any DBS checks for staff employed at the practice. We were provided with a risk assessment which demonstrated that a DBS check was not required for a member of non-clinical staff. We were told this member of staff acted as a chaperone. However, this information was not included as part of the risk assessment. Therefore, we could not be sure the appropriate checks had been completed for staff employed at the practice.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
<p>Explanation of any answers and additional evidence:</p> <p>We asked to see evidence of checks carried out by the provider on staff employed to work at the practice, including details of staff immunisations. We were provided with the recruitment files of 4 staff members. We saw that the provider had seen the employment history for all 4 staff members. However, the provider was unable to demonstrate they had evidence of: proof of identity; signed contract; pre-employment references; DBS checks; qualifications; registration with professional organisations (where required); induction checklists; and a signed confidentiality policy.</p> <p>The provider had a staff immunisation policy that stated all patient facing staff should be up to date with routine immunisations including; tetanus; diphtheria; polio; and measles, mumps and rubella (MMR). However, there were incomplete records held of staff immunisations. We saw evidence that one member of staff had received immunisation against Hepatitis B and another member of staff had received Bacillus Calmette-Guerin (BCG), MMR and varicella vaccinations. However, there were no other records for these staff members. We viewed 2 additional staff files; these contained no information on the immunisation status of these staff members.</p> <p>Therefore, we could not be sure the provider had completed the appropriate recruitment checks or recorded staff vaccination details in line with current guidance.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 11 May 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: Actions from fire risk assessment were identified and completed.	No
<p>Explanation of any answers and additional evidence:</p> <p>We saw that the provider had completed a health and safety risk assessment on 11 May 2022 and a premises and security risk assessment on 5 June 2022. These risk assessments identified potential risks in the practice and the control measures to mitigate the risks.</p> <p>We asked to see a fire risk assessment for the premises, however the provider told us this had not been completed. The provider told us they had contacted a specialist company to attend the practice to complete this risk assessment, however we were not provided with a date for completion. Therefore we could not be sure that the provider had identified, and taken appropriate action to mitigate the risks of fire. We were sent 2 documents relating to fire safety. One was named fire safety and contained general information on how to reduce the risks of fire, but was not specific to the practice. This document was not dated. A second document named fire safety policy was reviewed in July 2022 and contained a fire safety checklist which stated there was an evacuation chair, and monthly checks of the warning system and firefighting equipment were completed.</p> <p>Records showed that calibration testing of equipment and portable appliance testing (PAT) had been carried out within the last 12 months.</p> <p>The provider had a fire evacuation plan, completed weekly testing of the fire alarm system and carried out fire drills. The most recent fire drill took place on 23 February 2022. Following this fire drill, recommendations were made. For example, the staff list needed to be updated as it contained details of staff who were no longer employed by the practice. The provider told us that an updated staff list was now included with the emergency grab bag.</p> <p>We reviewed the training records of 5 staff members and found all had received fire safety training. Staff told us the names of staff who were designated fire marshals. We asked for evidence that these staff members had received fire marshal training, but this was not provided to us. We were told that several staff members were to be booked on a fire marshal training course in the future.</p> <p>According to a practice procedure document, emergency lighting tests should have been carried out at the practice every 3-5 weeks. However, testing had not been completed in August, October or November 2022. The provider told us this was due to lack of staff at the practice.</p> <p>There was a health and safety notice in reception, however this did not carry details of the local health and safety representative. After the inspection the provider wrote to us with evidence to show these details had been added.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always 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: 6 October 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	No
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We found there was a clinical waste bin stored securely, however we found this to be unlocked. Staff told us that this was because the lock did not work. After the inspection the provider wrote to us with evidence to show a clinical waste bin had been purchased for use in the practice to replace the faulty clinical waste bin. We saw evidence that an IPC audit had been completed on 6 October 2022 and had identified issues that required action. For example, there was a rip in the couch in a nurse's room and a rip in a chair in a consulting room. The audit stated that this had been reported to the practice manager, however we could not see evidence that action had been taken to resolve the issues, nor was there a date for completion.	

Risks to patients

There were gaps in 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.	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.	Partial
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	Partial
Explanation of any answers and additional evidence: The practice had a comprehensive business continuity plan for major incidents such as; power failure or building damage. The plan included emergency contact numbers. We saw there was an inventory of emergency equipment and that regular monitoring took place. The provider held one set of adult defibrillator pads and did not keep an additional set. After the inspection the provider wrote to us with evidence that an additional set of adult defibrillator pads had been purchased for use at the practice.	

There was written guidance for staff to follow to help them identify and manage patients with severe infections. For example, the sepsis policy. We saw evidence that staff had received training in the recognition and management of patients with severe infections such as sepsis.

We looked at the records of 5 staff members and found that 2 members of non-clinical staff had not completed training in basic life support. After our inspection the provider told us that 1 of these staff members had completed this training in December 2022, and 1 staff member was booked on a basic life support training course in January 2023.

Keypad locks from the waiting room to the back of reception and from the main stairs to the administration area on the third floor were not always in use. Staff at the practice told us that security had been increased at the practice following an incident where a patient was verbally aggressive and was able to access staff only areas of the practice. After the inspection the provider told us that the keypad in reception was now in use and they were attempting to fix the keypad on the third floor. If this was not fixable, a new keypad would be purchased.

The practice had a visit from an external company to assess the risks of legionella on 16 June 2022 (legionella is a bacterium found in water supplies which can cause severe respiratory illness). Water sampling was carried out as part of the visit and found that the presence of legionella was not detected at the premises.

We saw evidence the temperature of water from hot and cold outlets had been monitored and recorded regularly from July to November 2022 and that these results were within recommended limits.

Staff told us there were insufficient staff employed at the practice and were currently working on recruiting additional staff. This included producing a “GP attraction package” which shared information during the recruitment process to encourage GPs to work in the local area. The provider told us they were currently trying to recruit sufficient GPs to provide an additional 8 sessions per week. They were also attempting to recruit an Advanced Nurse Practitioner, as well as nursing and administrative staff.

Information to deliver safe care and treatment

Staff had some information they needed to deliver safe care and treatment. However, improvements were required.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
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.	No

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	No
<p>Explanation of any answers and additional evidence:</p> <p>We looked at the management of documents and test results within the practice's systems. We found there were 344 lab results dated from October to November 2022 which had not been viewed or acted upon. The provider reviewed these lab results after our inspection and found that many of these results were duplicates and that appropriate action had been taken for these patients.</p> <p>We saw there were 916 tasks showing in the practice's system dating from June 2021 to November 2022. It was unclear whether these tasks had been completed.</p> <p>The practice's systems showed there were also other outstanding documents, including incoming correspondence about patients, dating from June 2020 to November 2022. It was unclear whether any action had been taken regarding these documents.</p> <p>After the inspection the provider wrote to us with evidence of how document and test results within the practice's systems would be managed in the future. This included additional training which had been provided to clinical and administrative staff.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, improvements were needed.

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

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.73	0.85	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	6.3%	8.9%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	6.03	5.77	5.31	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	178.5‰	132.5‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>	0.99	0.61	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	6.5‰	6.8‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	No
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	No
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 structured medicines reviews for patients on repeat medicines.	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.	Partial
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.	Partial

Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p data-bbox="57 405 1543 450">Explanation of any answers and additional evidence, including from clinical searches.</p> <p data-bbox="57 483 1543 595">We found that 18 patients were prescribed Azathioprine (an immunosuppressant). We looked at the records of 5 of these patients and found that although 3 patients had not had the required monitoring, they had all been invited to attend for monitoring tests on multiple occasions.</p> <p data-bbox="57 640 1543 909">We identified that 128 patients prescribed an ACE inhibitor or Angiotensin II receptor blocker (medicines used to lower blood pressure) had not had the required monitoring tests. We reviewed 5 records and found all 5 patients needed blood tests. We could not see evidence that monitoring had been checked prior to issuing prescriptions. After the inspection the provider wrote to us with evidence that the notes of these patients had been reviewed, learning points had been identified and an action plan had been developed. The action plan included recall for patients identified as part of these searches and the development of a system to allow for pro-active monitoring.</p> <p data-bbox="57 954 1543 1133">We saw that there was an inventory of emergency medicines held and regular monitoring took place. The provider did not have the following emergency medicines on the day of inspection; diclofenac; buccal midazolam/rectal diazepam. The provider had not assessed the risk of not holding these medicines. After the inspection the provider wrote to us with evidence that rectal diazepam had been purchased for use at the practice. However, we did not see evidence of any action taken to risk assess or purchase diclofenac.</p> <p data-bbox="57 1178 1543 1335">The provider did not log serial numbers of blank prescription pads when they were first received into the practice, nor were they tracked through the practice. After the inspection the provider wrote to us with evidence of a log and a procedure that had been shared with GPs on how to record the receipt and movement of prescription forms throughout the practice.</p> <p data-bbox="57 1379 1543 1559">We looked at 5 patient group directions (PGDs) and found that 1 was out of date and all had been completed incorrectly. For example, the authorising manager had signed the PGD before some members of staff, meaning that those staff members did not have authorisation to administer the medicine. After the inspection the provider wrote to us with evidence that the 5 PGDs had now been completed correctly and were all in date.</p> <p data-bbox="57 1603 1543 1715">The provider had a refrigerator for the storage of vaccines. The temperatures of this refrigerator were monitored and recorded regularly. Records showed that the temperatures remained within acceptable limits and we saw vaccines were stored appropriately within the refrigerator.</p>	

Track record on safety and lessons learned and improvements made

The practice did not have a robust 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.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	11
Number of events that required action:	11
Explanation of any answers and additional evidence:	
<p>During our inspection staff told us there were no records of significant events available for us to review. After the inspection the provider wrote to us with evidence of a significant event log dated January to September 2022 containing 11 significant events. This log lacked detail of the event itself, the action taken and evidence of shared learning. Records showed a significant event was discussed at a clinical meeting on 4 October 2022. The minutes recorded there were issues with test results and referrals. However, there was insufficient detail to be able to understand the incident that had occurred, the actions taken, and whether any learning had been shared as a result. The meeting was attended by clinical staff only, it was unclear if this event had been shared with non-clinical staff.</p>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence:	
<p>The provider was unable to demonstrate that all relevant safety alerts had been responded to. For example, we identified 5 patients over the age of 65 who were prescribed Citalopram 40mg (an anti-depressant). We reviewed all 5 of these patients' records and found there was no evidence that 3 of these patients had been informed of the risks of taking this medicine. After the inspection the provider wrote to us with evidence that these 3 patients had been booked for a consultation with a GP to discuss their medicine. The provider had an action plan, which included 6-monthly reviews of patients prescribed this medicine and the use of a register to ensure all patients receive timely reviews.</p>	

Effective

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing effective services because:

- Patients' needs were not always assessed, and care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- The practice was unable to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.
- The practice always obtained consent to care and treatment. However, DNACPR decisions were not always made in line with legislation and guidance.

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 not always assessed, and care and treatment were not always 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.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
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
Explanation of any answers and additional evidence: Improvements to care and treatment were required to some types of patient reviews. For example, patients with asthma, hypothyroidism and diabetic retinopathy.	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered and taken up by patients over 75 years of age.
- Influenza, shingles and pneumonia vaccinations were offered to relevant patients.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- 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 demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

During our inspection, we completed a series of searches on the practice's clinical records system. These searches were completed with consent and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.

We looked at 5 medicine reviews and found these had been completed to a high standard.

We reviewed 5 patients who had been prescribed 2 or more courses of rescue steroids and found that best practice guidance had been followed for these patients.

We found 27 patients with asthma had been prescribed 12 or more Short-Acting Beta Agonist (SABA) inhalers in the last 12 months. We looked at the records of 5 of these patients. One patient had received appropriate monitoring and review. Four patients were overdue both asthma and medicine reviews. After the inspection the provider wrote to us with an action plan showing that these patients would receive appropriate reviews.

Our searches identified 2 patients with Chronic Kidney Disease (CKD) Stages 4 or 5 who had not had appropriate monitoring within the last 18 months. Following review of these records, we found that 1 patient had monitoring tests carried out elsewhere and the other was overdue. After the inspection the provider wrote to us with evidence that this patient had now received the appropriate monitoring tests.

We found 31 patients with hypothyroidism had not had appropriate monitoring within the last 18 months. We reviewed the records of 5 patients and found that none of these patients had monitoring tests, or adequate recall to attend for these. After the inspection the provider wrote to us with evidence that the

notes of these patients had been reviewed, learning points had been identified and an action plan had been developed. The action plan included recall for patients identified as part of these searches and the development of a system to allow for pro-active monitoring.

We looked at the records of 5 patients with diabetic retinopathy (diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the back of the eye. It can cause blindness if left undiagnosed and untreated). Four patients had received appropriate management of this condition. One patient appeared to be prescribed medicines that were not adequately managing their condition. After the inspection, the provider wrote to us with an action plan for management of this patient in the future.

Patients with long-term conditions received a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

Staff who were responsible for reviews of patients with long-term conditions had received specific training.

GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

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)	101	113	89.4%	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)	101	118	85.6%	Below 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)	102	118	86.4%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	102	118	86.4%	Below 90% minimum

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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)	125	142	88.0%	Below 90% minimum

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

Any additional evidence or comments

The provider was aware of the NHS England results (published in March 2021) which showed that uptake rates for childhood immunisations were lower than the World Health Organisation (WHO) minimum target of 90% for five indicators. The provider told us an administrative safeguarding lead had recently been employed by the practice who had attempted to improve uptake by; contacting parents/guardians to advise to book for immunisations; contacting parents/guardians of children who were not brought to appointments; placing alerts on the system so that health care professionals could discuss with patients when they attended the practice for other reasons.

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: 31/03/2022) (UK Health and Security Agency)	64.8%	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)	66.3%	63.4%	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)	64.3%	68.0%	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)	54.2%	56.4%	55.4%	No statistical variation

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

Any additional evidence or comments
The provider was aware of NHS England results (published March 2022) which showed that the uptake of cervical cancer screening was below the target of 80%. The provider told us that one reason for these figures was the lack of available nurse appointments and high numbers of patients who did not attend for their appointments, but also did not cancel prior to their non-attendance. The provider told us that in an attempt to increase uptake for cervical screening; they regularly reviewed the updated figures and sent recall text messages to remind patients of the need to book an appointment; and used opportunistic appointment bookings, when a patient attended the practice for other matters. The provider told us that they were also attempting to recruit nursing staff to provide additional nurse appointments.

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

The provider sent evidence of 2 clinical audits that had been carried out in the last 2 years. For example, an audit had been completed on patients who were prescribed metformin (prescribed to treat type-2 diabetes) and who also had reduced renal function. This audit was completed in order to reduce the risk of a rare but serious metabolic condition. Initially 8 patients were identified who met the criteria and received appropriate reviews. The audit was repeated 3 months later and found that there were no patients who met the criteria. The provider added these criteria to the high-risk drug searches to ensure appropriate future monitoring.

Effective staffing

The practice was unable to demonstrate that all 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.	Partial
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Partial
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.	No
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
Explanation of any answers and additional evidence:	
Not all relevant staff were up to date with safeguarding training; basic life support training; chaperone training; and fire marshal training.	
We asked to see the appraisal records for 5 members of staff. We were not provided with these records so we could not be sure if they had received an appraisal or not.	
Staff told us that they were not always given protected time to complete required learning.	
We saw there was an induction process for new staff and were told by the provider that inductions took place. However, we asked to see a completed induction checklist for 5 members of staff. We were not provided with induction checklists for 4 of these staff members. Therefore, we could not be sure that all staff had received an induction appropriate to their role.	

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.	Yes
Patients received consistent, coordinated, person-centred 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

Consent to care and treatment

The practice always obtained consent to care and treatment. However, DNACPR decisions were not always made 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.	Partial
Explanation of any answers and additional evidence	
We reviewed 3 patients' records that contained DNACPR decisions. We found none of these decisions had been recorded correctly. For example, none of the records contained review dates, and 2 of the records did not include reasons why Cardio-Pulmonary Resuscitation (CPR) would be inappropriate.	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive 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
NHS reviews website	<p>There were 14 reviews on the NHS website. Feedback about the service was mixed and referred to:</p> <ul style="list-style-type: none">• Praise for the GPs.• Friendly and efficient nursing team.• Long waits on the telephone to access appointments.• Difficulty accessing repeat prescriptions.
Experience shared with CQC directly via our website	<p>There were 4 comments shared with CQC directly. Feedback about the service was negative and referred to:</p> <ul style="list-style-type: none">• Difficulty accessing appointments and prescriptions.• Arrangements for patients receiving end-of-life care.

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)	81.3%	82.1%	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)	84.3%	80.8%	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)	98.0%	92.0%	93.1%	Tending towards variation (positive)
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)	59.5%	66.8%	72.4%	No statistical variation

Any additional evidence or comments

Feedback about the practice from the national GP patient survey published in April 2022 was positive and in line with local and England averages.

Question

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

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)	93.5%	89.0%	89.9%	No statistical variation

Any additional evidence or comments

Feedback about the practice from the national GP patient survey published in April 2022 was positive and in line with local and England averages.

	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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified that there were 416 carers on the practice list (4% of the practice population).
How the practice supported carers (including young carers).	The practice had a carers register and had processes to ensure this was updated regularly.
How the practice supported recently bereaved patients.	Recently bereaved patients received a telephone call from one of the GPs and were signposted to local support and bereavement counselling services.

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: Requires Improvement

We rated the practice as Requires Improvement for providing responsive services because:

- Complaints were not used to improve the quality of care.

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:	
Areas of the practice were accessible to people using wheelchairs or mobility scooters. Toilets were accessible to people with limited mobility and there were designated baby changing facilities.	

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

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none">Patients had a named GP who supported them in whatever setting they lived.

<ul style="list-style-type: none"> • The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. • Appointments were available outside of school hours so that school age children did not need to miss school. • All parents or guardians calling with concerns about a child aged 5 or under were offered a same day appointment when necessary. • The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability. • People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
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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
<p>Explanation of any answers and additional evidence:</p> <p>There were multiple appointment types available, including face to face, telephone and video consultations. Patients were able to book appointments in person, on the telephone and via eConsult (online).</p> <p>On the day of inspection, we looked at the practice's appointment system and found the next available face to face appointment with a GP was on 24 November 2022, the next available face to face appointment with a nurse was on 25 November 2022, and the next available telephone appointment was on 24 November 2022.</p>	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England 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)	21.9%	N/A	52.7%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	29.8%	48.6%	56.2%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	34.2%	48.2%	55.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	76.8%	68.2%	71.9%	No statistical variation

Any additional evidence or comments

The national GP patient survey showed lower than average satisfaction scores for 3 of 4 indicators. The provider had responded to negative feedback about access to the practice by implementing a new telephone system in November 2022. This system offered more options for patients to select, which was introduced to reduce the waiting times on the telephone. The system also allowed for call monitoring, staff told us there were plans to use this in the future to further improve patient experience.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	0
Number of complaints we examined.	0
Number of complaints we examined that were satisfactorily handled in a timely way.	0
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.	No
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection the provider told us that there were no records of complaints received in the last year. However, the practice had received 3 complaints via NHS England in the last 3 years. We saw that complaints were discussed at clinical meetings on 2 August 2022 and 15 November 2022. For example, at the clinical meeting on 15 November 2022, there was discussion of a patient who had been told the wrong date of their appointment and on attending could not be seen by a GP as all were fully booked. The patient was given another appointment; however, this was for a blood test that required the patient to fast, and the patient was not given this information. The meeting minutes showed the GP was to make an apology to the patient. The meeting minutes did not show the complaint had been investigated to identify any learning points to be shared with staff. The meeting was attended by clinical staff only, there was no evidence that this information had been shared with non-clinical staff.</p>	

Well-led

Rating: Inadequate

We rated the practice as Inadequate for providing Well-led services because:

- There was compassionate and inclusive leadership. However, improvements were needed to ensure the delivery of high quality sustainable care.
- The practice had a culture which drove high quality sustainable care. However, the provider was unable to demonstrate they had an effective complaints procedure.
- There were some responsibilities and roles to support good governance and management. However, improvements were needed to systems of accountability for the management of backlogs of activity.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- There was little evidence of systems and processes for learning, continuous improvement and innovation.

Leadership capacity and capability

There was compassionate and inclusive leadership, however improvements were needed to help ensure the delivery of high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	No
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:	
Staff told us that they felt supported by the management team and that leaders were visible and approachable.	
We requested a copy of the practice's clinical governance policy. We were told the practice did not have a clinical governance policy, but arrangements for clinical governance were covered in other practice policies. However, there was no evidence of the arrangements for clinical governance within the policies provided to us.	
The provider told us that they were aware that improvements to quality, safety and performance were required. However, action was required in relation to the following:	
<ul style="list-style-type: none"> • Safeguarding • Fire safety • Infection prevention and control • Medicines management • Health and safety • Management of incoming documents and test results • Monitoring of some patients with long-term conditions 	

- Complaints management
- Significant events management
- Management of palliative care records
- Staff training
- Staff personnel files
- Practice specific policies, namely safeguarding children, safeguarding adults and clinical governance.

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 provider told us that the vision of the practice was to deliver quality, safe care to all patients.	

Culture

The practice had a culture which drove high quality sustainable care. However, the provider was unable to demonstrate they had an effective complaints procedure.

	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.	Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
Staff told us that they worked in a caring and inclusive environment and they felt valued in their role. We asked 18 staff members if they had access to a Freedom to Speak Up Guardian, 11 staff members were	

unsure whether there was a named person who they could raise concerns with. The confidentiality policy did not contain the details of an external person or organisation where staff could raise concerns.

The provider had a complaints policy which said that complainants would receive a response to their complaint. The policy stated that this response included a factual chronology of events and contained an apology if something had gone wrong. We requested, but were not provided with, examples of responses to patient complaints. Therefore we could not be sure of compliance with the duty of candour or that people received an apology when they were affected by things that went wrong.

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

Source	Feedback
Staff feedback forms	We received 17 feedback forms from staff at the practice. There were many positive comments with staff commenting on the supportive environment, caring staff and the friendly, patient-focused team. There were also comments on areas that could be improved with staff suggesting that they would like protected time for training, formal communication could be improved, and that the practice would benefit from additional clinical and non-clinical staff.

Governance arrangements

There were some responsibilities and roles to support good governance and management. However, improvements were needed to systems of accountability for the management of backlogs of activity.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found there were 916 tasks on the practice's computer system view dating from June 2021 to November 2022. It was unclear if these tasks had either been completed and not marked as such or not completed. We found 344 lab results that had not been viewed, dating from October to November 2022. There were documents requiring action for one of the GP dating from June 2020 to November 2022. It was unclear whether these documents had been viewed or action had been taken where required. We requested an action plan from the provider as to how documents and results will be managed in the future. We were told that:	

- The backlog of 916 tasks had been cleared.
- 80% of the outstanding lab results had been actioned. The provider had investigated and found that some of these results were duplicates and that all patients had received timely treatment.
- Staff were receiving support with the practice's computer systems, including additional training for clinical and administrative staff to support the management of documents and results.

We requested 20 governance documents and were provided with 17. We were not provided with policies for safeguarding children, safeguarding adults or clinical governance. The documents that were provided to us were reviewed regularly. However, the information governance policy did not contain information specific to the practice. The confidentiality policy did not contain the details of an external person or organisation where staff could raise concerns.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
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.	No
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:	
<p>The provider was unable to demonstrate their systems and processes were effective in the management of risks from:</p> <ul style="list-style-type: none"> • The practice's computer system not alerting staff of family and other household members of children that were on the risk register. • Fire safety; infection prevention and control; and health and safety risks. • The lack of some emergency equipment and emergency medicines that were required to be kept. • The lack of appropriate management of the prescribing of some high-risk medicines. • The management of safety alerts. • The management of documents and test results. • The continued review of patients with long-term conditions, in line with current best practice guidance. • The management of significant events. • The management of complaints. • The management of palliative care records, including record keeping for DNACPR orders. • Staff recruitment, training and vaccination records not being in line with regulatory requirements. • Staff not having the appropriate authorisation to administer medicines. 	

- The storage and management of blank prescriptions pads.
- The health and safety poster not carrying details of the local health and safety representative.

After we told the provider about these findings from our inspection, we saw evidence to show that they took immediate action to address management of risks from:

- Staff not having the appropriate authorisation to administer medicines.
- The storage and management of blank prescriptions pads.
- The health and safety poster not carrying details of the local health and safety representative.

The provider had a comprehensive action plan which detailed how they planned to monitor and improve systems and processes for:

- The lack of appropriate management of the prescribing of some high-risk medicines.
- The management of safety alerts.
- The management of documents and test results.
- The continued review of patients with long-term conditions, in line with current best practice guidance.

However, action was still required to demonstrate their systems and processes were effective in the management of risks from:

- The practice's computer system not alerting staff of family and other household members of children that were on the risk register.
- Fire safety; infection prevention and control; and health and safety risk.
- The lack of some emergency equipment and emergency medicines that were required to be kept.
- The management of significant events.
- The management of complaints.
- The management of palliative care records, including record keeping for DNACPR orders.
- Staff recruitment, training and vaccination records not being in line with regulatory requirements.

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

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.	Yes
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:	
The practice continued to operate throughout the pandemic providing a range of appointments including; face to face, video and telephone consultations, as well as home visits.	

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 had an active patient participation group (known at the practice as the patient council) with approximately 45 members who held meetings with practice representatives every 3 months. We saw examples where the patient council had shared ideas for improvement and actions the provider had taken in response to these. For example, some consultation rooms became very hot during the summer months. The patient council suggested the use of window blinds to keep the rooms cool and this idea had been implemented. Members of the patient council told us that they felt involved with decisions made at the practice and had developed good relationships with the leadership team.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence: We saw there was some discussion of complaints during clinical staff meetings. However, there was no evidence that significant events and complaints were used to make improvements nor was there evidence that learning was shared with relevant staff.	

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.