

Inspection Evidence Table

St James Medical Practice

(1-538714669)

Inspection Date: 12 October 2023

Date of data download: 28/09/2023

Overall rating: Requires Improvement

We have rated the practice requires improvement overall as safety and governance systems and processes needed strengthening. This included strengthening of recruitment systems, systems to monitor staff training and systems to share learning from incidents and complaints.

Context

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the second lowest decile (2 of 10). The lower the decile, the more deprived the practice population is relative to others. According to the latest available data, the ethnic make-up of the practice area is 79% White, 13% Asian, 4% Black, 3% Mixed, and 1% Other.

Safe

Rating: Requires Improvement

We have rated the practice as requires improvement for providing safe services as we found the processes for managing staff training, recruitment processes and infection control processes needed strengthening to ensure risks were identified and mitigated.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y

The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Clinical meetings were held every week. However, on reviewing a random sample of meeting minutes we found no evidence to demonstrate that safeguarding concerns were an agenda item and discussed with the clinical team to highlight any ongoing concerns. Staff meetings were not held on a regular basis. There was no set date for meetings and no set agenda. We were unable to gain assurances that safeguarding concerns were shared with the wider practice team. Safeguarding meetings were held every 6 months with the health visiting team to discuss safeguarding concerns. Evidence provided showed the last meeting was held in June 2023. The practice had a designated safeguarding lead in place to manage and support the safeguarding of adults and children. Records we examined showed that staff had a DBS check in place. (A DBS check is a way for employers check your criminal record, to help decide whether a person is suitable to work for them. This includes deciding whether it is suitable for them to work with children or vulnerable adults). All staff received safeguarding training and staff records showed that clinical and non-clinical staff had completed training which was appropriate to their role. Alerts were added to patient records to highlight safeguarding concerns. The practice had policies and processes to support staff in this area and staff were clear on how they accessed these policies. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed 4 personnel files and found there were gaps in appropriate checks such as previous employment record, proof of identity and clinical staff files had no evidence to demonstrate that clinical registration checks had been completed. Personnel folders were not organised. We found information of two other employees in the folder of another. We were unable to gain assurances that there was a systematic approach to ensure that personnel folders were managed appropriately. We found for some staff there was information relating to immunisation status that was outstanding and there were no risk assessments in place for staff who had not received the Hepatitis B vaccine to demonstrate potential risks of infection had been considered for both staff and patients. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment: August 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: August 2023	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • A health and safety risk assessment had been completed in August 2023; however, the risk assessment had not identified that 14 members of staff had not updated their training in this area. • Fire safety policies were in place and evidence was provided of a completed fire risk assessment. However, we found 7 members of staff had not completed training in fire safety. • Fire marshals had undertaken additional training for the role. Systems were in place for the regular checks of fire alarms, extinguishers and fire evacuation procedures. • We were told that fire drills were carried out every 6 months. Evidence provided showed that that last fire drill had taken place in April 2023. There had been no drills between September 2021 and December 2022. • The practice had completed assessments in place for the control of hazardous substances. • Evidence provided by the practice showed equipment was regularly calibrated and electrical items were PAT (portable appliance testing) tested. • The practice had a system in place for regular water temperature checks. A Legionella risk assessment had been completed in September 2022. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Partial
Date of last infection prevention and control audit: September 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	N
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"> • An infection control audit had been carried out in September 2023; however, the audit was incomplete, with no overall score recorded and no action plan in place. Staff told us that they had not been given protected time to complete the audit and implement an action plan. 	

- The infection control audit had identified a number of areas for improvement. These included walls not being in a good state of repair, flooring in treatment room required fixing and some blinds in the clinical areas were made of fabric or broken. No actions had been taken to address the potential risks identified.
- Policies were in place for infection prevention and control and accessible for all staff.

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • On reviewing a range of staff personnel files, we found no evidence to demonstrate that all staff had completed an induction on commencing employment. • We found no staff had been trained in sepsis awareness and there was no information available to staff on what actions to take in an emergency. Following the inspection, we were told that staff had commenced sepsis awareness training. • Reception and administration staff who handled calls to the practice and arranged appointments with the clinical team were aware of potential red flag symptoms. Staff knew when to notify a GP or other clinicians with concerns about a patient who may be acutely unwell and/or deteriorating. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y

Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. • There was a system in place to ensure all patient information including documents, laboratory test results and cytology reports were reviewed and actioned in a timely manner. • We found that test results were managed in a timely way and all workflow was followed up and actioned appropriately. • Our review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients. • The practice had established systems for monitoring two week wait referrals to ensure patients were seen. • The practice held multidisciplinary meetings with other agencies to share and discuss information relating to patient care and treatment, for example, those on the practice palliative care register. 	

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation.

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2022 to 30/09/2023) (NHSBSA)	0.70	0.90	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2022 to 30/09/2023) (NHSBSA)	4.3%	5.8%	7.8%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2023 to 30/09/2023) (NHSBSA)	5.79	5.22	5.19	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)	163.1‰	142.7‰	130.7‰	No statistical variation

Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2022 to 30/09/2023) (NHSBSA)	1.26	0.60	0.53	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)	10.1‰	8.9‰	6.8‰	No statistical variation

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

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

- On the day of inspection, we spoke with one of the clinical team concerning the high prescribing of hypnotic and psychotropic medicines. The practice were aware of the high number of medicines being prescribed in these categories and told us the pharmacist was currently reviewing patients to identify who needed a medicine review. The practice also informed us that they had seen an increase in patients joining the practice who were on these types of medicines.
- The practice had no formal process in place to monitor the prescribing competencies of non-medical prescribers. Staff told us that if they had a concern, they would approach a GP or pharmacist for support, however we were unable to gain assurances that there was an effective clinical supervision process in place and there was regular review of their prescribing practice supported by clinical supervision or peer review.
- On reviewing the prescription collection box, we found there was no process in place to manage and monitor the length of time prescriptions had been waiting for collection. For example: We found a prescription dated 2020 and numerous prescriptions dated 2022. On speaking with staff, they were unable to tell us about the process if prescriptions were not collected.
- We carried out a range of clinical searches and identified no concerns. For example: We found 565 patients on medicines used for the treatment of cardiovascular and renal diseases and potentially 31 patients had not received the appropriate monitoring. We reviewed a random sample of 5 patients and found all were up to date with the required monitoring.
- Clinical searches showed that in the past three months 755 patients had received a medicine review. We reviewed a random sample of five patients and found two patients had been coded as having medicines reviews, however we found one record showed no detail of patient contact and the second patient had been coded as medicine review completed by a GP, but only one medicine of eight had been reviewed.
- Emergency medicines, vaccines and medical equipment were appropriately stored and there were clear monitoring processes in place.
- There were appropriate arrangements in place for the management of vaccines and for maintaining the cold chain. We saw fridge temperatures were routinely monitored and vaccines reviewed at random were in date and stored appropriately.
- We looked at patient group directives (PGDs - a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). We saw that they had been authorised appropriately.

Track record on safety and lessons learned and improvements made

The practice did not have a system to share learning and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y

There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	3
Number of events that required action:	3
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a system in place for recording significant events, however we were unable to gain assurances that the outcomes of the event were shared with staff to promote learning and mitigate future risks. On reviewing a random sample of clinical meeting minutes, there was no evidence to demonstrate that significant events were a standing agenda item and discussed within the team to share learning. 	

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

Event	Specific action taken
Blood tests not actioned	<ul style="list-style-type: none"> Clinical staff reminded to send a task to the reception/administration staff if a blood result required actioning. Blood test results to be regularly monitored to ensure future risk is mitigated.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a system in place to review and action safety alerts. We carried out a clinical search for a safety alert concerning medicines used to lower blood sugar by causing the kidneys to remove sugar from the body through the urine and the potential risks of Fournier's gangrene. We found 143 patients on these types of medicines. We reviewed a random sample of five patients and a note had been made on the patients records to state that possible side effects had been discussed. 	

Effective

Rating: Requires Improvement

We have rated the practice as requires improvement for providing effective services as the practice were unable to demonstrate they had effective systems in place for the induction and training of staff and cancer screening uptake was below target.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	

- On reviewing staff training information, we found 3 GPs who worked at the practice were not up to date with mental health or Deprivation of Liberty (DOLS) training. On the day of inspection, we were provided with up to date certificates to show 2 of the GPs had completed this training.
- We carried out a range of clinical searches to review patients with long term conditions. One of the searches showed 362 patients were on the asthma register. We found a potential of 38 patients who had been prescribed two or more courses of rescue steroids. We reviewed a random sample of five patient records and found all 5 patients had been followed up in line with the recommended guidelines following an exacerbation and all 5 patients had received a recent asthma review. However, we were unable to determine from reviewing the clinical records that the patients had been issued a steroid card. (A Steroid Treatment Card carries a series of instructions for the patient and informs healthcare professionals of the details of the steroids prescribed).
- We carried out a review of the clinical system to identify patients with stage 4 or 5 kidney disease. Our search indicated 66 patients potentially had not had urea and electrolyte monitoring in the past nine months as recommended by clinical guidelines. We reviewed 5 records and found patients had received the appropriate monitoring.

Effective care for the practice population

Findings

- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- 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 took into account the needs of those whose circumstances may make them vulnerable. The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice 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

- On reviewing the clinical system, we identified 247 patients with hypothyroidism and 18 patients who had potentially not had the appropriate monitoring in the past 18 months. We reviewed a random sample of 5 of these patients' records and found all patients had been sent requests to attend for monitoring.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	61	63	96.8%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	55	63	87.3%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	54	63	85.7%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	54	63	85.7%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	59	66	89.4%	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

- We were told that children who had missed their appointments, were followed up and staff encouraged patients to attend.
- Frequent non-attenders were referred to the health visiting team.
- Staff told us that due to the diverse population at the practice, it was difficult to get patients to engage in the immunisation programme.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	34.6%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	59.8%	N/A	70.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	26.3%	48.4%	54.9%	No statistical variation
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). (6/30/2023 to 6/30/2023) (UKHSA)	59.9%	N/A	80.0%	Below 70% uptake

Any additional evidence or comments
<ul style="list-style-type: none"> • Following the inspection, we received unverified data from the practice which showed that on 3 April 2023 the practice had achieved 58% for breast cancer screening and 63% for bowel cancer screening. • The practice's uptake with cervical cancer screening was below the national target of 80% and practice staff were aware of this and had taken action to try to improve the uptake of cervical cancer screening. • Staff told us the importance of cervical cancer screening was discussed with patients at every opportunity. • Patients were followed up if they failed to attend. • Staff told us that cultural barriers impacted on the number of patients attending for screening.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: <ul style="list-style-type: none"> • A clinical audit of medicines prescribed for the use of neuropathic pain had been completed due to the high prescribing of these medicines at the practice. The aim of the audit was to reduce the number of new prescriptions for these medicines and to review existing patients to check if the medicines were still needed. A clinical search was completed to identify patients on these medicines and a total of 8 patients 	

were identified. Each patient was reviewed and information was shared on the risks associated with these medicines and other alternatives for managing pain were discussed with the patients.

- The practice planned to run the search every 3 to 6 months to identify the number of patients that had been newly prescribed and to search for patients who have continued on these medicines.
- The outcome of the audit was discussed at a clinical meeting and the pharmacists shared prescribing data and ideas on how to support patients managing chronic pain.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	N
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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff told us they were encouraged to learn and develop; however, they were not provided with protected learning time to do this. Staff had been given extra roles within the practice, but no time had been allocated for them to do these extra duties. • The provider told us they had a program of learning, however on reviewing staff training information we found some staff had not completed training updates. This included health & safety and fire training. There was no system in place to ensure staff had received sepsis awareness training to support them within their role. • On reviewing a random sample of staff files, we found there was no evidence to demonstrate that all staff had received an induction. • The practice had no formal process in place to monitor the competencies of staff in advanced clinical practice. Staff told us that if they had a concern, they would approach a GP or pharmacist for support, however, we were unable to gain assurances that there was an effective clinical supervision process in place. 	

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Evidence was provided to demonstrate that regular meetings were held with community teams to ensure information was shared across the teams to provide patients with co-ordinated care. Systems were in place to share information about patients electronically with other services. 	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

Explanation of any answers and additional evidence:

- Our clinical review of patient records where a DNACPR decision had been recorded, indicated where possible the patients' views had been sought and respected and we saw that information had been shared with relevant agencies.

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.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we spoke with demonstrated the values of the practice and dealt with patients with kindness, respect, and compassion. Interactions we observed between staff and patients, showed that staff listened to patients and treated them with kindness. 	

Patient feedback	
Source	Feedback
NHS.uk website (formerly NHS Choices)	The practice had received 2 reviews both were 5 star and said doctors and staff are helpful and very pleased with the services received.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	84.8%	78.8%	85.0%	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 (01/01/2023 to 30/04/2023)	84.9%	77.2%	83.8%	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	89.4%	89.5%	93.0%	No statistical variation

healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	78.0%	61.1%	71.3%	No statistical variation

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

Any additional evidence

The practice had commenced the Friends and Family test from June 2023. A breakdown of the results showed that during August and September a total of 388 responses had been received. On reviewing the results 354 patients had said the practice was good or very good.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	84.8%	85.3%	90.3%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y

Information about support groups was available on the practice website.	Y
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Carers	Narrative
Percentage and number of carers identified.	190 carers. This represented 3.8% of the practice population.
How the practice supported carers (including young carers).	Carers were offered flu vaccinations and carers review on an annual basis.
How the practice supported recently bereaved patients.	The practice told us they had no support in place for patients who were recently bereaved.

Privacy and dignity

The practice respected / did not always respect patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Due to the size of the waiting area, it was very easy to overhear conversations that were being held at the reception desk. Staff had access to private rooms away from reception if the patient requested it. 	

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Patients had a range of options to book appointments, these included online, by telephone or face to face. • Extended access appointments were available every Monday and Wednesday evenings from 6.30pm to 8pm. • Patients were able to access appointments outside of the practice opening times at other local practices as part of the primary care network. These included Saturday from 9am to 4.30pm. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm 6.30pm – 8pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm 6.30pm – 8pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8.30am to 11.30am

	3.30pm to 6.30pm 6.30pm to 8pm
Tuesday	8.30am to 11.30am 3.30pm to 6.30pm
Wednesday	8.30am to 11.30am 3.30pm to 6.30pm 6.30pm to 8pm
Thursday	8.30am to 11.30am 3.30pm to 6.30pm
Friday	8.30am to 11.30am 3.30pm to 6.30pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available on a Monday morning for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child under the age of 5 years, were offered a same day appointment when necessary.
- Pre-bookable appointments were available to all patients at additional locations within the area, as the practice was a member of a GP primary care network. Appointments were available Saturday from 9am to 4.30pm.
- The practice held a register of patients living in vulnerable circumstances including 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.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y

There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had commenced the NHS Friends and Family test in June 2023. Results for July and August 2023 demonstrated 91% of patients rated the practice as good or very good. Appointments were available online, by telephone and face to face. There had been no negative patient feedback online concerning access. 	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	67.1%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	55.5%	44.3%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	63.2%	46.5%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	76.6%	65.8%	72.0%	No statistical variation

Source	Feedback
CQC feedback	We have not received any feedback about this service in the last 12 months.
NHS.uk website (formerly NHS Choices)	There were 2 comments since December 2022. One comment related to the phone system and getting through, however as the practice had a queuing system, it advised patients where they were in the queue. Comments highlighted how pleased they were with the practice.

Listening and learning from concerns and complaints

Learning from complaints was not shared to improve the quality of care.

Complaints	
Number of complaints received in the last year.	5
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a complaints procedure in place and information on raising a complaint was available in the practice and on the website. • The provider could not demonstrate how learning from complaints was shared with the practice team. We found that meetings were not held regularly and we were not provided with any evidence to demonstrate that complaints had been discussed with staff to share learning. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient attended for appointment; felt they were not listened to.	<ul style="list-style-type: none"> • Patient was spoken with and offered an alternative clinician. • Concerns shared with GP for learning.

Well-led

Rating: Requires Improvement

We have rated the practice as requires improvement for providing well led services as governance processes required strengthening to ensure risks were identified and mitigated.

Leadership capacity and capability

There was compassionate and inclusive at all levels, however this was not always effective.

	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.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found the governance systems and processes in place at the practice needed strengthening. On speaking with the leadership team, they told us they would review all processes to ensure there was an effective leadership programme in place to address quality and any challenges that arose. Staff told us that the partners were approachable and supportive. The management team were highly regarded by staff and had an open-door policy so staff could approach them at any time if they had concerns. The practice had no succession plan in place. However, had recently recruited a new partner to support the existing clinical team. 	

Vision and strategy

The practice had no clear vision or 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.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> On speaking with a range of staff they were unaware of a vision or set of values that the practice had to work towards to achieve its goals. 	

- The leadership team told us that following the announcement of the CQC inspection, they had reflected on what improvements were needed to demonstrate quality and ideas were being discussed to make changes.
- The new GP partner had a plan to make improvements to the practice which included the introduction of a quality team to monitor the practice and services provided. However, at the time of the inspection this was still a plan and we found no evidence to demonstrate that this was being put in place.

Culture

The practice culture did not effectively support 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.	Partial
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.	Partial
Staff had undertaken equality and diversity training.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a whistle blowing policy in place which detailed the freedom to speak up guardian, however not all staff were aware that there was someone outside of the practice they could approach if they needed too. • Some staff reported they were provided with no time to do extra duties they had been allocated and this had impacted on work being delayed. For example: the infection control action plan. • We found no evidence to demonstrate that staff had completed equality and diversity training. 	

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

Source	Feedback
Staff	Staff told us that the leadership team were supportive and everyone worked well together as a team.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The leadership team had identified that clear roles and responsibilities needed to be better defined to ensure all staff were aware of what their role entailed. On speaking with staff in advanced roles, we found that communication was lacking and improvements were required to ensure staff were aware of latest developments and changes that had been made. Provider policies and procedures were available which were accessible to all staff. Discussions with staff showed they had an understanding and awareness of key policies such as safeguarding. We looked at a sample of policies and saw they had been reviewed; however, we did find that some governance systems required strengthening further such as recruitment, immunisations and mandatory training. The practice had no set structure for staff meetings. The leadership team informed us that a meeting had been held recently once the practice had been notified of the inspection, however they were unable to recall when the previous staff meeting had been held. 	

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.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p>	

- The practice had a range of risk assessments in place; however, we were unable to gain assurances that these were effective and monitored on a regular basis. An audit for infection control had been completed in September 2023, however no action plan was in place to act on the concerns identified.
- No regular reviews for fire or health and safety were carried out. A fire risk assessment was in place, however it lacked information on what had been reviewed and detailed only the fire fighting equipment that was available.
- There was a major incident plan in place, however on reviewing the policy it contained no information of who staff had to contact within the leadership team if an issue arose.
- The leadership team had an oversight of risks such as incidents and complaints and there were some systems to identify risks, however this needed strengthening as potential risks has not been acted on. These included infection control action plan, staff training, staff immunisation status and recruitment processes.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Data was used to monitor and improve performance. Systems were in place to enable regular clinical searches in areas such as long-term conditions and medicine management. • The practice was aware that they were high prescribers of psychotropic medicines and had completed an audit to identify where improvements could be made. The practice planned to run the search every 6 months to identify the number of patients that had been newly prescribed and to search for patients who continued on these medicines. • We carried out a range of remote clinical searches and identified no concerns relating to data used to support decisions about patient care and treatment. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y

Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a patient participation group; however, no meetings had been held to share information or updates with the group. Staff meetings were not held regularly, with the last staff meeting being held on 3 October 2023. We were told this was due to the CQC having announced the inspection of the practice. The leadership team were unable to recall when the last staff meeting had been held prior to the October meeting. We were unable to gain assurances that staff input was reflected in the planning of services. We were told by some of the clinical team that ideas and suggestions were listened too at the clinical meetings, however we found no evidence to demonstrate this in the minutes we reviewed. The practice had collated the responses from patients who had completed the NHS Friends and Family test for August and September 2023. The outcome of the feedback received was positive with 91% of patients rating the practice as good or very good. 	

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.	Partial
Learning was shared effectively and used to make improvements.	N

Explanation of any answers and additional evidence:

- The practice was a training practice for GP registrars to support them with their ongoing learning of primary care.
- On speaking with staff, they told us they were encouraged to develop and learn; however, no time was provided for them to training updates.
- The provider told us they had a program of learning; however, we identified gaps in staff training updates. For example: 14 staff had not completed health & safety training and 7 staff had not completed fire awareness training. on reviewing staff training information, we found some staff had not completed 27 training updates. This included health & safety and fire training. There was no system in place to ensure staff had received sepsis awareness training to support them within their role.
- We found limited evidence to demonstrate that learning from complaints and significant events was shared with staff to make improvements and mitigate future risks.
- The outcome of clinical audits was used to make improvements to the quality of care provided at the practice and discussed with the clinical team to ensure learning was shared.

Examples of continuous learning and improvement

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of 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 those aged 25 to 49, and within 5.5 years for those 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.