

Care Quality Commission

Inspection Evidence Table

Shakespeare Road PMS (1-8585296229)

Inspection date: 28 April to 9 May 2022

Date of data download: 28 April 2022

Overall rating: Requires Improvement

This inspection was a comprehensive inspection that looked at all five key questions. It took place between the 28 April and 9 May 2022 and included a remote review of patient clinical records, interviews with staff and a site visit. This was the first inspection of this location since their registration with CQC.

Following this inspection, we rated the location as requires improvement overall and for the safe, effective and well-led key questions because; appropriate standards of cleanliness and hygiene were not met, the practice's systems for the appropriate and safe use of medicines were not always effective, there was limited monitoring of the outcomes of care and treatment, the practice was not always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles, childhood immunisation and cancer screening data were below targets, the practice did not have clear and effective processes for managing risks, issues and performance, and did not always act on appropriate and accurate information. However, the practice had clear systems, practices and processes to keep people safe and safeguarded from abuse; staff had the information they needed to deliver safe care and treatment; staff worked well together and with other organisations; staff were consistent and proactive in helping patients to live healthier lives; and staff obtained consent to care and treatment in line with legislation and guidance.

We rated the caring and responsive key questions as good because; staff treated patients with kindness and compassion; staff respected patients' privacy and dignity and helped patients to be involved in decisions about care and treatment; the practice organised services to meet patients' needs; and people were able to access care and treatment in a timely way.

Safe

Rating: Requires Improvement

The practice is rated as requires improvement for providing safe services because; not all staff were trained to appropriate levels for their role; appropriate standards of cleanliness and hygiene were not met; and the practice's systems for the appropriate and safe use of medicines were not always effective. However, the practice had clear systems, practices and processes to keep people safe and safeguarded from abuse, and staff had the information they needed to deliver safe care and treatment.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However, not all staff were trained to appropriate levels for their role.

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.	N
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.	Y
Explanation of any answers and additional evidence:	
The practice had named leads for safeguarding for both adults and children. The practice had procedures in place to ensure patients were safeguarded from harm and staff escalated concerns promptly. Staff monitored children and patients who did not attend appointments, including for vaccinations and immunisations, and took action to follow these up. The practice had formed good working relationships with other health and social care services, including school nurses, children's social care and secondary area, to allow for any safeguarding concerns to be shared.	
Staff placed safeguarding alerts to the records of potentially vulnerable adults and children to alert clinicians. However, alerts were not always entered onto the records of any parents or siblings of children with safeguarding concerns. We raised this as a concern to the practice as part of our inspection, and saw the practice took immediate action to rectify this. This included adding a high priority alert to the relevant patient records, creating a search to review all patients with safeguarding alerts, and implementation of an annual review process of all flagged records.	
All clinical staff were required to complete safeguarding training to a minimum of level three; however, training data showed not all staff had achieved this. Non-clinical staff were required to complete safeguarding training to a minimum of level one. Although training data showed all non-clinical staff had	

Safeguarding	Y/N/Partial
achieved this, this was not in line with the <i>Roles and Competencies for Healthcare Staff</i> intercollegiate document that recommends for all non-clinical staff with patient contact to undertake a minimum of level two training. However, upon our review of staff files, we did see evidence that some staff had undertaken training to level three standard that was not recorded in the practice's training data.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>All new staff joining the practice were required to undergo a series of recruitment checks that included the obtaining of two references and a check of the applicant's identity, qualifications and professional registrations.</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: October 2021	Y
There was a fire procedure. Date of fire risk assessment: 14/02/2022	Y
Actions from fire risk assessment were identified and completed.	Y

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.	P
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 17/06/2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	P
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Non-clinical staff were required to complete training to a minimum of level one standard, and training records evidenced all non-clinical staff had completed this training. Clinical staff were required to complete training to a level two standard; however, training data did not evidence all staff had completed this training.</p>	

The practice completed yearly infection prevention and control audits, which covered several areas including treatment rooms, hand hygiene and training. Areas of non-compliance were highlighted and escalated for remediation. However, we noted some areas such as staff training compliance were marked as 'achieved in full' despite training data showing that several staff were overdue training.

During our inspection, we reviewed the cleanliness of waiting areas, staff rooms and clinic rooms. Although clinical areas were seen to be visibly clean, several areas of the practice appeared not to be cleaned regularly or in line with the practice's cleaning schedule. For example, several hand washing sinks were seen to have significant build-up of limescale which could pose an infection risk, with one sink seen to be visibly dirty and mouldy. Other areas of the practice were seen to have noticeable build-up of dirt and dust, indicating the lack of a recent or regular clean. We raised this concern to the practice as part of our inspection, who advised they would urgently escalate this to their external cleaning contractors.

The practice had not undertaken a legionella risk assessment to determine any potential risks associated with legionella bacteria. Although regular checks of hot and cold water temperatures were taken, staff were unclear what temperatures would be considered a concern and required escalation. We saw the thermometer used to take these temperatures was not appropriate, due to only reading to a maximum of 50°C.

Following our inspection, the practice undertook a repeat infection prevention and control audit, and created an action plan to address any areas of non-compliance. A legionella risk assessment had since been completed, with an appropriate thermometer purchased to support this. The practice had removed any limescale build-up on taps, and had escalated cleaning requirements to their cleaning contractor for rectification.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	P
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence:	
All staff received training on cardiopulmonary resuscitation, with clinical staff repeating this training every 18 months and non-clinical staff every three years. At the time of our inspection, training data showed all staff had last completed this in October 2020, which meant all clinical staff were overdue. This was	

also not in line with guidance from the Resuscitation Council UK, which recommends for staff to have at least annual updates on resuscitation. The practice explained this was due to difficulties arranging training during the COVID-19 pandemic, and had booked staff on a training course in June 2022.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
The practice had an established system in place for managing test results and referrals, including urgent two week wait referrals. As part of our inspection, we conducted a series of remote clinical records searches to review the practice's processes for referral management. At the end of the inspection day, we saw there were no significant outstanding tasks relating to patients that were waiting to be actioned. Although there were 86 results that were waiting to be viewed, all of these had been received within the preceding 48 hours.	

Appropriate and safe use of medicines

The practice's systems for the appropriate and safe use of medicines, including medicines optimisation, were not always effective.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.71	0.83	0.76	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total	4.7%	6.6%	9.2%	Variation (positive)

Indicator	Practice	CCG average	England average	England comparison
number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2021 to 31/12/2021) <small>(NHSBSA)</small>				
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 (01/07/2021 to 31/12/2021) <small>(NHSBSA)</small>	5.74	5.53	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) <small>(NHSBSA)</small>	51.9‰	147.8‰	129.2‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) <small>(NHSBSA)</small>	0.57	0.63	0.62	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) <small>(NHSBSA)</small>	4.8‰	5.6‰	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.	N
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 structured medicines reviews for patients on repeat medicines.	P
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y

Medicines management	Y/N/Partial
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	P
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 PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice stored all blank prescriptions securely and removed these from all clinic rooms when not in use. Although the practice held records of when new blank prescriptions were delivered and when they were assigned to a specific prescriber, the process was not effective and did not allow for effective reconciliation and tracking of blank prescriptions.</p> <p>Staff had access to a range of emergency medicines and equipment, which were clearly signed. However, these were stored loose across several shelves within a locked cabinet within a lockable treatment room. This was not in line with guidance from the Resuscitation Council UK, which states emergency medicines should be stored in tamperproof boxes, be readily accessible in an emergency and not locked away. As emergency equipment was stored loose within cupboards, this posed a risk that equipment could not easily be moved to a patient in the event of an emergency. Although a range of emergency medicines were stocked, the practice had not conducted a risk assessment to review the range and quantity of medicines that should be held by the practice.</p> <p>Following our inspection, the practice conducted a risk assessment with regards to emergency medicines to review the range and quantity of medicines to be stored. A new tamperproof medicines box was purchased, which was placed in a readily accessible location in the practice.</p> <p>Patients received regular structured medication reviews, which were usually conducted by practice pharmacists. As part of our inspection, we reviewed completed medication reviews and saw these were completed to a high standard, with reviews encompassing all medications and including a discussion of compliance and side effects. Medication reviews were also completed by GPs; however, we saw these were completed to a variable standard. Although records were updated to indicate a medication review had taken place, these did not always include a formal or structured discussion of all medicines or a review of any side effects, and documentation was not always clear as to what was discussed with the patient.</p>	

Medicines management	Y/N/Partial
<p>The practice did not have a formal process in place for the ongoing assessment and review of the prescribing competency of non-medical prescribers. Staff explained their prescribing was overseen by a named GP mentor, and prior to the COVID-19 pandemic, any prescribing concerns would be discussed during clinical meetings. However, these discussions were not documented or recorded, and the clinical meetings had temporarily ceased as a result of the pandemic.</p> <p>As part of our inspection, we conducted a series of searches to review the practice's procedures around medicines management and prescribing. One search reviewed the prescribing of a high risk medicine primarily used to treat arthritis. Our search identified 11 patients who were prescribed this medicine, with all patients observed to have received all recommended monitoring.</p> <p>Another search identified patients prescribed a high risk medicine primarily used to treat inflammatory conditions. Our search identified five patients prescribed this medicine, with all five patients observed to have received all required monitoring.</p> <p>Another search identified patients prescribed a high risk medicine primarily used to treat arthritis. Our search identified one patient prescribed this medicine, with all monitoring observed to be up-to-date.</p> <p>Another search identified patients prescribed a high risk medicine primarily used to treat mood disorders. Our search identified two patients prescribed this medicine, although one patient was managed by secondary care. We noted the second patient was up-to-date with some monitoring tests; however, were overdue some additional recommended monitoring tests. We raised this with the practice, who took action following our inspection to escalate the monitoring of both patients with secondary care teams.</p> <p>Another search identified patients prescribed a high risk medicine primarily used to treat heart failure. Our search identified 17 patients prescribed this medicine, with five patients identified as not having received all recommended monitoring. We undertook a detailed review of three patients' records and saw all patients received appropriate annual monitoring, although not all patients had received all recommended interim monitoring. Following our inspection, the practice advised they had messaged all affected patients to invite them for a blood test and had implemented a process to ensure all interim monitoring was maintained.</p> <p>Another search identified patients prescribed a high risk medicine primarily used to control blood pressure. Our search identified 470 patients prescribed this medicine, with 21 patients identified as not having received all recommended monitoring. We noted one patient had not received all recommended monitoring despite having a recent medication review. Following our inspection, the practice advised they had messaged all affected patients to invite them for any outstanding monitoring tests.</p> <p>A final search reviewed any overprescribing of short-acting reliever inhalers, primarily used to treat asthma. Well-controlled asthma is associated with little or no need for reliever inhalers, so a need for excess reliever inhalers can be a sign of poorly controlled asthma. Our search identified 43 patients who were prescribed more than 12 inhalers in the last 12 months, of which 25 of these patients did not have a diagnosis of chronic obstructive pulmonary disease (COPD) – a group of lung conditions that includes emphysema and chronic bronchitis. We undertook a detailed review of two patients' records and saw one patient had recently received an asthma review, and although the second patient was overdue their review, the practice had attempted to contact the patient to arrange a review.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, processes for the management of safety alerts required improvement.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	1
Number of events that required action:	1
Explanation of any answers and additional evidence: All incidents were discussed at clinical meetings, with any learnings shared with all practice staff. Although clinical meetings had temporarily ceased as a result of the COVID-19 pandemic, the practice planned on introducing these from May 2022. In the 12 months prior to our inspection, the practice had only reported one incident; however, the practice had reported three incidents in the 12 months before that.	

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

Event	Specific action taken
Incorrect coding of diagnosis	Incident investigated and discussed at clinical meeting; induction pack introduced to support locum and agency staff who may be unfamiliar with practice systems and processes.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: Safety alerts were received by the nurse prescriber, who recorded these on a central list and cascaded them to relevant staff, such as GP and pharmacy teams. Although recent alerts were seen to be acted on appropriately, some older alerts appear to have been missed, and there was not a process in place for reviewing historic safety alerts. As part of our inspection, we conducted a series of searches to review the practice's procedures for managing safety alerts. One search reviewed a safety alert from 2014 regarding the interactions between two medicines when prescribed together. Our search identified two patients who were potentially still prescribed both medicines. We undertook a detailed review of both patients' records and	

saw one patient had recently been switched to an alternative medicine; however, one patient still remained at risk. Following our inspection, the practice advised they had taken action to ensure this patient was no longer at risk.

A second search reviewed a separate alert from 2014 regarding the interactions between two medicines when prescribed together. Our search identified three patients who were potentially still prescribed both medicines. We undertook a detailed review of all three patients' record and saw two patients had recently been switched to an alternative medicine; however, one patient still remained at risk. Following our inspection, the practice advised they had taken action to ensure this patient was no longer at risk.

As part of our search, we reviewed the quality of five patient medication reviews. During this, we identified one patient was prescribed a medicine that was highlighted in a 2018 safety alert as potentially increasing a patient's risk of skin cancer. We saw the patient was still prescribed this medicine, however had not been informed of this risk or advisory actions. Following our inspection, the practice advised they had taken action to ensure this patient was no longer at risk.

As part of our review of high risk medicines, we reviewed the prescribing of a medicine used primarily to treat arthritis. Following a safety alert in 2020, it was recommended for patient prescriptions to be updated to include the day of the week when the medicine should be taken. Although we saw all patients were receiving appropriate monitoring, we noted the day of the week had not been added to the patients' prescription. We raised this as a concern to the practice, who reviewed the affected patients and made the appropriate amendments to prescriptions as necessary.

Effective

Rating: Requires Improvement

The practice is rated as requires improvement for providing effective services because; there was limited monitoring of the outcomes of care and treatment; the practice was not always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles; and childhood immunisation and cancer screening data were below targets. However, staff worked well together and with other organisations, were consistent and proactive in helping patients to live healthier lives, and always obtained consent to care and treatment in line with legislation and guidance.

QOF requirements were modified by NHS England 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 were delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence:	
The practice's policy was for all clinicians to keep themselves up-to-date with the latest guidance. We noted GPs had attended seminars regarding changes to guidance, with discussions held with other clinicians and pharmacists as a result. As part of our inspection, we conducted a series of remote clinical records searches and saw national guidance was being followed, such as suspected cancer pathways.	

Effective care for the practice population

Findings

- The practice had a system for vaccinating patients according to the recommended schedule, which included flu, shingles and pneumonia vaccinations.
- All patients with a learning disability were offered an annual health check.
- Health checks were offered to patients, which included annual health checks to patients aged over 75 years of age and 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.
- 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 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, and referred patients to appropriate services as required.

Management of people with long term conditions

Findings

As part of our inspection, we conducted a series of remote patient clinical records searches to review the practice's procedures for the management of patients with long term conditions:

- Our first search reviewed patients with a potential missed diagnosis of diabetes and from this search we identified three patients with a potential missed diagnosis. Two of these patients were diabetic and were having appropriate reviews; however, neither patient had been coded correctly meaning there was a risk they could be missed from future screening or other communications. The third patient had been marked to show their diabetes had been resolved; however, as the patient was still taking diabetic medication, this was incorrect.
- A further search reviewed the management of patients with asthma who have been prescribed two or more courses of rescue steroids within the last 12 months. Guidance from the National Institute for Health and Care Excellence (NICE) recommends patients should be reviewed within 48 hours of an acute asthma exacerbation to review the patient's response, due to an increased risk of death if the exacerbation is not managed. Our search identified 16 patients who had been prescribed two or more courses of rescue steroids, from which we undertook a detailed review of five patients' records. We noted four patients had received regular asthma reviews, and although two of these patients had not been followed up within a week of the exacerbation, we saw the practice had provided both patients with good safety netting advice. A fifth patient had not had a confirmed diagnosis of asthma and was waiting a follow-up appointment to discuss this. Following our inspection, the practice confirmed they had reviewed the affected patients and had implemented a new process to recall all patients within one week of an exacerbation where steroids were prescribed.

- A further search reviewed the monitoring of patients with chronic kidney disease at stages four and five. Our search identified one patient who had not received all recommended monitoring; however, this patient was receiving treatment from secondary care.
- A further search reviewed the monitoring of patients with hypothyroidism. Our search identified four patients who were prescribed this medicine who had not received all required monitoring. We undertook a detailed review of all four patients' records and saw three patients were either receiving monitoring by secondary care or had been contacted by the practice for a review. Although a fourth patient had not received any monitoring since 2020, the provider explained local agreements in place allowed for two-yearly monitoring for stable patients.
- A final search reviewed the care and treatment of patients diagnosed with diabetic retinopathy – a complication of diabetes caused by high blood sugar levels. Our search identified 53 patients, from which we undertook a detailed review of five patients' records. We saw all five patients had received a recent diabetic review and had been followed up after monitoring checks with advice on diabetes control. However, we noted one patient was overdue a medication review and two patients had blood pressure readings above the recommended range but there was not a documented discussion about this.

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)	65	79	82.3%	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)	65	78	83.3%	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) (01/04/2020 to 31/03/2021) (NHS England)	64	78	82.1%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England)	65	78	83.3%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles,	68	88	77.3%	Below 80% uptake

mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England)				
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

The practice had not achieved the minimum 90% target for any of the above childhood immunisation indicators, and performance on these indicators had all declined since March 2020. For example, the percentage of children aged two who have received the Hib/MenC booster had declined from 95.6% in March 2020 to 82.1% in March 2021.

We raised this as a concern to the practice, who explained this was largely due to their patient population which included a large number of different nationalities and had been working to improve this. For example, the practice had identified that many patients did not speak English; however, immunisation information was only available in English. As a result, the practice had employed a member of staff who spoke languages spoken by their local community and had worked on developing patient information leaflets in other languages. As part of our inspection, we reviewed several patient clinical records and saw evidence the practice contacted patients when immunisation appointments had been missed, or arranged home visits where patients could not attend the practice.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (Public Health England)	51.5%	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) (PHE)	12.5%	59.0%	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) (PHE)	46.3%	67.3%	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) (PHE)	30.8%	49.0%	55.4%	No statistical variation

Any additional evidence or comments

The practice had not achieved the minimum 80% target for the uptake of cervical screening. We raised this as a concern to the practice who explained this was due to low participation from their patient population. As part of our inspection, we reviewed several patient clinical records and saw evidence of the practice contacting patients to invite them for screening appointments, including when repeat

screens were due. Unvalidated performance data that excluded patients who had declined to engage in the screening programme showed the practice had exceeded the 80% target.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

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

Any additional evidence or comments

Although the practice had undertaken some audits and quality improvement work, there was no formalised plan or programme of clinical audit in place. Managers explained this was as a result of the COVID-19 pandemic and planned on increasing their audit programme shortly.

In the 12 months prior to our inspection, the practice had conducted one audit regarding patients who had died within the past two years with a diagnosis of COVID-19. We reviewed this audit and saw one action had been identified regarding the creation of a pre-set text message that would be sent to patients who were identified as not having completed the full course of COVID-19 vaccinations and booster vaccinations.

Effective staffing

The practice was not always able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	P
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	P
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	P

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> <p>Staff training records did not demonstrate that all staff had completed all required training. All staff were required to undertake regular training on several topics, which included data security awareness, preventing radicalisation, suicide prevention, fire safety, and moving and handling. Although most non-clinical staff were seen to have completed this training, several clinical staff members had not completed all required training. For example, we reviewed the training records for GP staff and saw none of the above required training courses had been completed. We raised this as a concern during our inspection and saw the practice had taken immediate action to rectify this, with staff completing training in these areas.</p> <p>Although training records were held, these did not always provide an effective overview of compliance. For example, training records for non-clinical staff indicated staff had only completed training to level one standard. However, upon a review of staff files, evidence of training to level three standard were seen.</p> <p>The practice was not always able to demonstrate how they assured the competence of clinical staff. Although staff described how they could raise queries or concerns to senior clinicians and discussed information during clinical meetings, there was no evidence of a formalised or documented process for the review and assessment of individual competency, or evidence of any formalised supervision or mentoring process in place. Additionally, at the time of our inspection, clinical meetings had been suspended as a result of the COVID-19 pandemic; however, the practice planned to reintroduce these in May 2022.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had developed close working relationships with other providers of health and social care and shared key information when required. This included to other providers of health and social care, which included palliative care, district nursing and out of hours services.</p>	

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
Explanation of any answers and additional evidence: The practice offered NHS health checks and referred patients to other services, including to specialist mental health support services, when required.	

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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: Patients and their relatives were involved in care and treatment decisions, including any discussion regarding end of life care. Clinicians recorded any DNACPR decisions on standard decision forms, and there was no evidence of any discrimination when decisions were made. Staff undertook regular reviews for care home and palliative care patients, which included a review of the patient's preferred place of care, any DNACPR decisions made, and any other wishes or requests of the patient. As part of our inspection, we undertook a review of three DNACPR decisions made within the 12 months prior to our inspection. We saw copies of all three DNACPR decision forms had been retained on the practice's clinical record system and were easy for staff to view. Consultation notes were clear, comprehensive and included reference to any involvement of patients' friends and family, any assessment of their mental capacity, and any discussions held with other healthcare services.	

Caring

Rating: Good

The practice is rated as good for providing caring services, as staff treated patients with kindness and compassion, and respected patients' privacy and dignity. Staff helped patients to be involved in decisions about care and treatment.

Kindness, respect and compassion

Staff treated treat 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

Patient feedback	
Source	Feedback
Google Reviews	In the 12 months prior to our inspection, five reviews were posted. Three out of five reviews contained positive comments about staff working at the practice and the service being good. The themes outlined in the remaining reviews were around getting through to the practice, and one review was negative about reception.
Interview with Patients	Feedback from patients spoken with as part of our inspection was positive, with patients describing staff as "really nice" and how "everyone knows me and looks after me".

National GP Patient Survey results

Indicator	Practice	CCG 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 (01/01/2021 to 31/03/2021)	88.4%	89.5%	89.4%	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	81.3%	88.8%	88.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
good at treating them with care and concern (01/01/2021 to 31/03/2021)				
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 (01/01/2021 to 31/03/2021)	91.9%	95.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	91.5%	83.1%	83.0%	No statistical variation

Any additional evidence or comments
The practice performed largely in line with local and national averages on the above indicators. Although some indicators were below local and national averages, we saw the practice had improved their performance in all the above indicators from the previous survey in March 2020. For example, regarding the percentage of respondents who stated the healthcare professional was good at treating them with care and concern, we saw this had improved from 77.9% in March 2020 to 81.3% by March 2021.

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

Any additional evidence
Although the practice had installed a suggestions box within the reception area for patients to provide feedback, the practice did not conduct any patient survey or feedback exercises. The practice reported this was largely due to the COVID-19 pandemic and planned on reintroducing the NHS Friends and Family Test survey shortly.

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
Staff could refer patients to local social prescribing teams and community navigators for support and advice. Information on these services was displayed clearly within the practice, including on	

noticeboards within the waiting area. The practice also displayed this information in other languages to ensure patients who did not speak English were aware of these services.

National GP Patient Survey results

Indicator	Practice	CCG 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 (01/01/2021 to 31/03/2021)	86.3%	92.4%	92.9%	No statistical variation

Any additional evidence or comments

Although the practice's performance on the above indicator was lower than local and national averages, the practice had improved on this from the previous survey. In the March 2020 survey, the practice had achieved 80.0%, with this improving to 86.3% in the March 2021 survey.

	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.	P
<p>Explanation of any answers and additional evidence:</p> <p>The practice employed several staff who spoke multiple languages, which included languages commonly spoken by the practice's local communities. The practice had enhanced this by working with local commissioners to run a weekly clinic whereby a face-to-face interpreter was available. This allowed patients who did not speak English, or who preferred to speak in their primary language, the ability to access care, treatment and services easily and equally.</p> <p>Although the practice detailed information on local support teams and groups within the practice waiting area, there was limited information of these on the practice's website.</p>	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 52 carers and one young carer. At the time of our inspection, the practice had 5,732 patients registered at the practice. This equated to a percentage of 0.91%.

How the practice supported carers (including young carers).	The practice could refer patients to community navigators and social prescribing link workers, who could support patients and carers in accessing support and advisory services, as well as providing information on access to financial, health and wellbeing support.
How the practice supported recently bereaved patients.	Recently bereaved patients were contacted by the lead GP who provided additional support and offered any follow-up appointments if required.

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.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us they always took steps to maintain patient privacy, and we observed staff closed consultation room doors when discussing confidential matters with patients. Chaperoning information was available throughout the practice, including in waiting areas and consultation rooms, and trained staff were available to fulfil this role.</p>	

Responsive

Rating: Good

The practice is rated as good for providing responsive services, as the practice organised services to meet patients' needs and people were able to access care and treatment in a timely way.

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> <p>The practice had a diverse local population, with patients from several communities registered at the practice. To ensure all patients could access care, treatment and services equally, the practice had made several adjustments and changes to their service. For example, the practice employed several staff who spoke multiple languages, and had facilities for on-site and remote interpreters to be arranged where needed. Patient information leaflets and signage were available in multiple languages, and where pre-translated leaflets could not be sourced, the practice had taken steps to translate these for patients and had shared these with other practices locally.</p> <p>The physical environment was accessible to patients who had limited mobility or used a wheelchair, and a hearing loop had been installed to assist patients who used hearing aids. The practice had processes in place to arrange British Sign Language interpreters for patients who were deaf or hard of hearing.</p> <p>The practice worked collaboratively with schools and community healthcare teams to inform and educate patients about vaccination and immunisation. This has included clinical staff hand delivering letters to patients in the community.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	7.15am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

Appointments available:	
Monday	9am to 11.30am; 4pm to 6pm (nurse prescriber appointments available from 7.15am to 8am)
Tuesday	9am to 11.30am; 4pm to 6pm
Wednesday	9am to 11.30am; 4pm to 6pm
Thursday	9am to 11.30am; 4pm to 6pm
Friday	9am to 11.30am; 4pm to 6pm

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.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice offered same day and pre-bookable appointments which could be arranged in person, by telephone or online. Due to the high rate of non-attendance, the practice sent patients reminders about their appointments.
- People in vulnerable circumstances were easily able to register with the practice, including patients who were refugees or had no fixed abode.

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	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	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
<p>Explanation of any answers and additional evidence:</p> <p>Patients could book appointments by telephone, online or by visiting the practice in person. To ensure patients who did not have access to telephone or online services were not disadvantaged during the pandemic, the practice continued to provide a face-to-face service to allow patients to book appointments in person.</p> <p>The practice operated an initial triage system, whereby receptionists booked patients with non-urgent medical conditions for a telephone call back with an appropriate clinician. If the patient required an urgent appointment or preferred to see a clinician face-to-face, then a face-to-face appointment could be arranged in the first instance. Although each clinician was responsible for managing their own triage list, staff could escalate patients with urgent medical needs to other clinicians as necessary.</p> <p>When booking appointments, receptionists followed a detailed appointment checklist that outlined the appointment types each clinical role could see, as well as detailing the estimated appointment length and appropriate appointment types. For example, we saw appointments for long term condition reviews were to be scheduled for a 30 minute telephone triage, whereas a flu vaccine appointment was to be scheduled for a 10 minute face-to-face appointment.</p> <p>In the event all appointments were taken, and a patient required an urgent medical appointment, the practice had processes in place for increasing additional capacity for emergency appointments. The practice operated a daily cancellation list, so if a patient did not show for an appointment or cancelled their appointment at last minute, patients could be contacted and asked to attend surgery later that day. If patients did not wish to use the cancellation list, then receptionists could book the patient a future appointment, book an evening or weekend appointment at one of the practice's extended access hubs, or would ask the patient to call from the next morning for a same day appointment.</p> <p>To support patients who could not attend the practice during normal hours, such as due to school, work or family commitments, the practice operated its own extended hours service whereby appointments were available with a nurse prescriber from 7.15am to 8am every Monday.</p>	

National GP Patient Survey results

Indicator	Practice	CCG 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 (01/01/2021 to 31/03/2021)	75.4%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to	80.0%	68.8%	70.6%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
the overall experience of making an appointment (01/01/2021 to 31/03/2021)				
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	75.9%	66.2%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	88.0%	81.2%	81.7%	No statistical variation

Source	Feedback
Google Reviews	In the 12 months prior to our inspection, the practice had received five reviews on Google. Three reviews were positive, with one reviewer stating they were “seen to straight away”. However, two reviews were negative, with one mentioning issues contacting the practice by telephone and the other mentioning the service received from receptionists.
NHS.uk Reviews	In the 12 months prior to our inspection, the practice had received one review on NHS.uk. This review was negative and mentioned difficulties contacting the practice by telephone and booking appointments.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	2
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: The practice took patient complaints seriously and undertook a detailed and effective investigation of all concerns received. Upon receipt of a complaint, the practice created a complaint management plan that	

outlined the key concerns raised, detailed how the complaint would be investigated, and how any learnings would be recorded and disseminated. The practice used this management plan to ensure it responded to any complaints in line with its complaints policy, as well as providing an effective audit trail of any investigation undertaken, any other services contacted, and any improvement or rectification work undertaken.

We reviewed both complaints received by the practice within the 12 months prior to our inspection and saw evidence of how the practice had responded to both concerns in a timely manner and had involved the patient and/or any relevant stakeholders in their investigation.

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint received regarding poor customer service.	Complaint investigated by the practice and discussed with staff involved. Formal response issued by practice to complainant.
Complaint received regarding management of test results.	Complaint investigated by the practice and discussed during clinical meeting. Formal response issued by practice to complainant.

Well-led

Rating: Requires Improvement

The practice is rated as requires improvement for providing well-led services, as the practice did not have clear and effective processes for managing risks, issues and performance, and did not always act on appropriate and accurate information. However, the practice had systems in place to continue to deliver services during the pandemic, and had a culture which drove high quality sustainable care.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The practice was led by two GP partners, who were supported by the practice manager. Leaders and managers understood the challenges the practice faced in delivering services to the local community. For example, managers described how the practice had a diverse local population, with patients speaking several different languages. To ensure all patients could receive effective care and treatment, the practice continued to address this challenge, such as by employing multilingual staff and holding dedicated clinics with face-to-face interpreters. The practice had a succession plan in place to ensure the right people were available to provide care. At the time of our inspection, the practice was in the process of recruiting new salaried GPs and nursing staff to fill planned staffing vacancies.	

Vision and strategy

The practice had a clear vision to provide high quality sustainable care, and progress against the delivery of their strategy was monitored.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice had an established aim to provide its patients with a “friendly and professional healthcare service for all the family”. To achieve this, the practice had several additional goals, which they outlined	

to patients within their practice leaflet. These included to involve patients as a “partner” in their care, to treat patients with “courtesy and respect”, and to provide all patients with a GP appointment within “two working days” decreasing to one working day for any urgent needs. Progress against the delivery of their strategy was monitored during regular management meetings.

Culture

The practice had a culture which drove high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff reported a positive culture and working environment, and described how they felt comfortable in raising any concerns to colleagues and managers, and were confident any concerns raised would be taken seriously. Managers were passionate about supporting and developing staff, and there were several examples where staff had been supported to take on additional responsibilities or had progressed into more senior roles within the practice.</p> <p>All staff were required to complete annual training on equality and diversity. Training records demonstrated all non-clinical staff and four of the five clinical staff had undertaken this training.</p> <p>The practice had a whistleblowing policy and procedure in place, which detailed to staff how they could raise concerns both internally and externally to the practice. This included contact information of the practice’s freedom to speak up guardian, who was an NHS England responsible officer.</p>	

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

Source	Feedback
Feedback from Staff	Feedback from staff who worked for the service was largely positive, with staff reporting how they felt “valued”, and described how they “supported each other” and had “good teamwork” in place.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: The practice had a clear governance structure in place, whereby the GP partners oversaw all clinical items and the practice manager oversaw all non-clinical and business matters. Staff of all roles were clear of their individual responsibilities and knew who to escalate any concerns to. The practice had a comprehensive set of policies and procedures in place, which were overseen and reviewed regularly by the practice manager and provided staff with all key information.	

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.	P
There were processes to manage performance.	P
There was a quality improvement programme in place.	P
There were effective arrangements for identifying, managing and mitigating risks.	P
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: As a result of the COVID-19 pandemic, the practice had not held any regular practice or clinical meetings. Whilst occasional meetings could be arranged, the lack of a regular management meeting meant that clinical incidents, safeguarding concerns and other issues that affected the practice were not discussed. The practice was in the process of reinstating these, with monthly clinical meetings resuming from May 2022; however, during our inspection, we identified several areas of concern that had not been adequately identified, addressed or mitigated by the practice. This included low mandatory training compliance, inconsistent infection prevention and control processes, lack of effective oversight of staff clinical competencies, lack of effective reconciliation of blank prescriptions, and medicines management concerns.	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the time of our inspection, the practice had not reported any significant backlogs or delays in care and treatment. Managers explained how the practice had remained open throughout the COVID-19 pandemic and had continued to offer a face-to-face service from their main practice location. This included the booking of appointments, as patients who did not have access to telephone or digital services could continue to make appointments by visiting the practice in person throughout the pandemic.</p>	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	P
Performance information was used to hold staff and management to account.	P
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Although the practice had made improvements to their service, there was limited evidence performance and management information data was used or reviewed when making changes to their service. This combined with the lack of regular clinical and management meetings at the time of our inspection meant there was not a formalised process in place to monitor and review practice performance information.</p>	

The practice submitted statutory notifications when required. For example, the practice had notified CQC of the temporary change of use of their branch practice site to a dedicated COVID-19 treatment and assessment hub at the start of the pandemic.

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	
The practice used a secure third-party system to store patient clinical records, through which information could be shared securely with other healthcare providers if appropriate. Online and remote consultations took place within normal consultation rooms to ensure patient confidentiality was maintained.	

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.	P
The practice had an active Patient Participation Group.	P
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	

Although the practice had set up a patient participation group, due to the COVID-19 pandemic the group had not met within the last two years and was not active at the time of our inspection. However, we did see evidence the practice had issued group members with a newsletter in January 2021 to update them with any key changes that had occurred at the practice since March 2020, as well as providing the practice manager's contact information.

The practice worked with stakeholders to develop and enhance their service for patients, such as working with commissioners to introduce a dedicated weekly clinic whereby a face-to-face interpreter was available for patients.

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.	P
Learning was shared effectively and used to make improvements.	P
<p>Explanation of any answers and additional evidence:</p> <p>Due to the COVID-19 pandemic, the practice had temporarily ceased or decreased some aspects of its operation. Although some continuous improvement and quality improvement work had been undertaken, there was no formalised plan or programme in place. There was a limited sharing of learning due to a lack of regular clinical meetings; however, the practice planned on reintroducing clinical meetings from May 2022.</p>	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- COPD:** Chronic Obstructive Pulmonary Disease.
- PHE:** Public Health England.
- 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.