

## Inspection Evidence Table

The Cottons Medical Centre

(1-562924493)

Inspection Date: 28 June 2023

Date of data download: 23/06/2023

**Overall rating: Good**

### Safe

**Rating: Good**

At the previous inspection in May 2022, we rated the practice as requires improvement for providing safe services because:

- There was a lack of effective clinical oversight. For example, there were gaps across some of the practice’s systems and processes to effectively monitor the safe use of medicines.
- The practice did not always operate an effective system for managing medicines safety alerts.

At this inspection, we found,

- Improvements had been made to the systems and processes in place to effectively monitor the safe use of medicines.
- The system for managing safety alerts was now embedded in the practice. We noted appropriate actions had been taken for safety alerts received.

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	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.	Y
<p>Explanation of any answers and additional evidence:  One of the GP partners was the safeguarding lead and staff were aware of the process to follow if they had a safeguarding concern. The lead was supported in the role by a safeguarding administrator.  Clinical and management staff were trained to level 3. Non-clinical staff were trained to level 2.  Alerts were used on the clinical system to identify patients and their families if there was a safeguarding concern. These alerts were visible to the Out of Hours service if a patient was seen out of practice working hours.  Safeguarding policies were available on the practice computer system.</p>	

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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: April 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: November 2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:  There was evidence that fire systems had been maintained and fire alarms were routinely checked. There were fire action and exit plans displayed in the practice.  Fire drills were carried out twice a year.</p>	

### Infection prevention and control

#### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: May 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y

The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:  A member of the nursing team was the lead for infection prevention and control (IPC). They had completed additional IPC training to undertake the role.  IPC audits were carried out every 3 months. Handwashing audits were completed for all new staff.  The practice was visibly clean and tidy.  There was a cleaning policy that contained timetables and schedules for cleaning to be completed.</p>	

### Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:  Administration and reception staff were trained to undertake all tasks to allow cover for absences and busy periods.  All staff had received training to recognise medical emergencies, including sepsis. Red flag symptoms were displayed in the reception area for reference.</p>	

### Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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: A review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.	

### Appropriate and safe use of medicines

#### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation.

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.98	0.93	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). (01/04/2022 to 31/03/2023) (NHSBSA)	6.0%	7.4%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) (NHSBSA)	5.06	5.12	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	188.5‰	134.2‰	129.8‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.40	0.56	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	9.9‰	7.7‰	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.	Y
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>There was a process in place for the review of patients prescribed high risk medicines. We carried out a remote search of the clinical system and found there were potentially 5 out of 7 patients who had not received monitoring when prescribed a medicine to treat rheumatoid arthritis. We reviewed 5 of these patients and found 2 had been monitored appropriately and 3 were overdue monitoring by 1 month. We noted that the practice had invited these patients for a review. However, they had not taken further action when the patients had not responded. Immediately following the inspection, the practice informed us that they had contacted the patients again.</p> <p>At the previous inspection in May 2022, we identified that 23 patients prescribed direct oral anticoagulants (DOACs) and novel oral anticoagulants (NOACs); blood thinning medicines were not appropriately monitored. At this inspection we carried out a remote search of the clinical system and found a significant improvement with no patients overdue monitoring.</p>	

**Track record on safety and lessons learned and improvements made**

**The practice learned and made 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.	Y
Number of events recorded in last 12 months:	4
Number of events that required action:	4
<p>Explanation of any answers and additional evidence:  There was a significant event policy that staff could access on the practice computer system. Significant event forms were completed that contained details of the event, any investigations and learning.  Significant events and the learning from them were discussed in clinical meetings and staff meetings.  Communications were also made via email to all staff.</p>	

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

Event	Specific action taken
COVID-19 vaccinations administered to care home residents were 1 day past the expiry date.	As soon as identified no more vaccinations were given. The manufacturer was contacted for guidance. Additional information was provided that showed there was an extended expiry date for thawed vaccines. There were no risks identified for residents. A process of additional checks was put in place on receipt of vaccines.
The wrong medicine was increased for a patient following a consultation.	The patient was offered a GP appointment the following day. No harm to the patient had occurred. The event was discussed at a multi-disciplinary team meeting. A new process was put in place to ensure additional checks were made when changing medicines.

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:  At the previous inspection in May 2022, we found the practice had failed to initially act on a safety alert on the combined use of a specific medicine used to treat stomach problems and another medicine used to prevent blood clots.</p> <p>At this inspection, we carried out a remote review of the clinical record system and found the system for recording and acting on safety alerts was embedded in the practice. We noted there were no patients prescribed the concomitant use of the specific medicine used to treat stomach problems and another medicine used to prevent blood clots.</p>	

The practice kept a log of all safety alerts and the actions taken. They carried out a review of the patient record system every 6 months to ensure guidance had been followed.

## Effective

**Rating: Good**

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

### Effective needs assessment, care and treatment

**Patients' needs were mainly 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.	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.	Partial
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:	

### Effective care for the practice population

#### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- All patients over 75 years of age had an allocated GP who was accountable for their care.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients.
- The practice had recruited community nurses who carried out weekly ward rounds and home visits for patients who were residents in care homes.
- 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

A remote review of the clinical record system showed the following,

- There were 45 patients diagnosed with asthma who had been prescribed 2 or more courses of rescue steroids for an exacerbation of their symptoms. We reviewed 5 of these patients and found that all patients had an adequate assessment undertaken at the time of prescribing. The practice were not always consistent with following up within 1 week of the prescription to check their response to the steroids.
- There were 491 patients diagnosed with hypothyroidism. Of these there were potentially 37 patients who were overdue monitoring. We reviewed 5 patients and found 4 of these were due a review of their medicines. All of these patients had up to date blood monitoring.
- There were 72 patients diagnosed with diabetic retinopathy who had a high blood glucose level. We reviewed 5 of these patients and found 3 were overdue a review of their medicines and 1 of these 3 also required a diabetes review. Discussions with the practice indicated that attempts had been made to contact these patients.

During the inspection we were advised by the practice that the GPs were working an extra session per week to complete all medicine reviews required.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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 suspected hypertension were offered ambulatory blood pressure monitoring.
- 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 influenzae 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)	97	99	98.0%	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)	129	132	97.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	129	132	97.7%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	128	132	97.0%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	117	122	95.9%	Met 95% WHO based target

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

Any additional evidence or comments
The practice had exceeded the World Health Organisation (WHO) target for all child immunisations. We were informed if children were not brought to the practice for immunisations the parents or guardians were contacted by telephone and letter. Educational leaflets were available on the benefits of immunisations.

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)	74.3%	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)	73.9%	N/A	70.3%	N/A

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). (12/31/2022 to 12/31/2022) (UKHSA)	76.4%	N/A	80.0%	Below 80% target
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)	46.4%	56.5%	54.9%	No statistical variation

### Any additional evidence or comments

The practice were aware they were below the 80% target for the uptake of cervical screening. They were training more staff to carry out the screening. If eligible patients did not attend for cervical screening they were contacted by letter and telephone and given the opportunity to discuss any worries or concerns. There was a noticeboard in the patient waiting area named the Butterfly Board which had butterfly symbols attached to represent every patient who had attended for cervical screening. Extended access appointments were available for eligible patients to attend in the evening or weekend for cervical 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
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

### Any additional evidence or comments

The practice had a programme of clinical audits in place that included areas of prescribing and actions from safety alerts. Outcomes of audits were shared and discussed at clinical meetings.

For example,

- An audit had been undertaken to ensure National Institute for Health and Care Excellence (NICE) guidelines were followed to monitor patients when they were prescribed medicines to lower cholesterol, known as statins. Following the 1<sup>st</sup> cycle of the audit the practice provided education and reminders for staff to carry out appropriate blood monitoring when patients commence taking statins and after 3 and 12 months. The 2<sup>nd</sup> cycle audit demonstrated an improvement.
- An audit had been undertaken to review the repeat prescriptions of 'Z drugs', these are medicines prescribed to treat insomnia. There is a risk of patients becoming dependent on these medicines. During the 1<sup>st</sup> cycle of the audit all patients were reviewed and where possible the strength of the medicine was reduced or stopped. The 2<sup>nd</sup> cycle of the audit demonstrated a 39% reduction in the prescribing of 'Z drugs'.

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: The practice had identified training that different staff groups should complete. Staff were given protected time to complete training.	

### 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: The practice carried out multi-disciplinary meetings with community staff every month to coordinate the care of patients with complex needs.	

### Helping patients to live healthier lives

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

	Y/N/Partial
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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 had access to a social prescriber through the primary care network who they could refer patients to for extra support. There were links to health information advice on the practice website.	

### 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 notes where a DNACPR decision had been recorded identified where possible patients views had been sought and respected. We saw that information had been shared with relevant agencies.	

## Responsive

## Rating: Requires Improvement

We rated the practice as requires improvement for providing responsive services because:

- Responses to the National GP Patient Survey showed patients were less than satisfied with access to the practice and making an appointment.
- Whilst the practice had taken actions to make improvements it was too soon to assess the impact of these.

### 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 worked as part of a Primary Care Network (PCN). PCNs are groups of GP practices collaborating with community, mental health, social care, pharmacy, hospital, and voluntary services in their areas to provide local services.</p> <p>All services were accessible on the ground level. There were automatic doors at the front entrance and the waiting area and corridors had sufficient space for wheelchairs and pushchairs. There was car parking available with a disabled parking bay. There were access enabled toilets and baby changing facilities. There was a hearing loop for patients who were hard of hearing and alerts were put on the patient record to allow these patients to make appointments in person rather than via the telephone.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
<p>Appointments were available throughout these times.</p> <p>Appointments were also available via the East Northants GP Extended Access Hub on Monday to Friday from 6.30pm to 8pm and on Saturday from 9am to 5pm. These appointments were available either at the practice or a neighbouring practice.</p>	

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>• Patients had a named GP who supported them in whatever setting they lived.</li> <li>• 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.</li> <li>• The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.</li> <li>• Appointments were available outside of school hours for children.</li> </ul>

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Translation services were available for patients who did not speak English or were hard of hearing.
- Patients who were hard of hearing were identified with an alert on the patient record to allow them to book appointments in the practice rather than via the telephone.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

**Access to the service**

**People were not always 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.	Partial
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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had changed their telephone system to a cloud based service. This enabled them to monitor the amount of calls they received and the amount they did not answer. They could view how many calls were incoming and adjust staff accordingly to answer calls at peak times.</p> <p>The practice recruited additional clinical staff to support the GPs and make more appointments available. For example, they employed community nurses to carry out home visits for patients in care homes and advance nurse practitioners to see patients with minor illnesses.</p> <p>We were informed patients who required a routine appointment were offered one within 2 weeks.</p>	

**National GP Patient Survey results**

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was	39.7%	N/A	52.7%	No statistical variation

to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	50.2%	55.4%	56.2%	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 (01/01/2022 to 30/04/2022)	43.5%	52.5%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	71.2%	72.2%	71.9%	No statistical variation

### Any additional evidence or comments

The practice had a quality improvement plan and access improvement plan in place that they had developed with the Integrated Care Board (ICB). This plan looked at how to manage incoming calls and appointment availability.

Call data, appointment availability and patient feedback was monitored at weekly meetings with the GP partners and the practice manager.

Online triage platforms were used to assess patients' symptoms to direct patients to the right service or health care professional.

National GP Patient Survey data published following the inspection, showed there had been a decline in some areas of patient satisfaction as follows:

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)	20.1%	N/A	49.6%	Significant variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	30.3%	50.8%	54.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	29.1%	50.1%	52.8%	Variation (negative)
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)	71.7%	71.4%	72.0%	No statistical variation

Source	Feedback
NHS.UK website (formerly NHS Choices)	There had been 8 reviews left on the NHS.UK website in the previous 12 months. There was 1 review with positive feedback regarding making an appointment and the care received from a practice nurse. There were 6 reviews that had negative comments regarding making appointments and staff attitudes and 1 regarding requests for blood test results. The practice manager had responded to the comments left and invited patients to contact the practice directly for their complaint to be addressed.

### 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.	30
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

Examples of learning from complaints.

Complaint	Specific action taken
Complaints regarding lack of empathy displayed to patients when making an appointment.	Recordings of the calls were listened to and the reception team were given training on communicating with patients and how to signpost them to alternative services if required.
Complaint regarding difficulty in making an appointment.	Available clinical staffing was reviewed and a locum GP was used to provide more appointments while recruitment of new permanent GPs took place.

**Well-led**

**Rating: Good**



### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	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 were aware of the challenges they faced with increased patient demand following the COVID-19 pandemic. They had worked with the local Integrated Commissioning Board to make improvements to access and appointments. There had been some changes to the partnership and additional clinical staff were recruited to support the GP partners.	

### Vision and strategy

**The practice had a clear vision and credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

### 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
Explanation of any answers and additional evidence: An external company was used to provide employee assistance if needed. Details of the helpline were displayed in the staff room.	

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

Source	Feedback
Staff	Feedback from staff was generally positive. Staff commented that they felt supported by the GPs and the practice manager and they enjoyed their job. Some staff commented that there were not always enough people available due to some staff leaving and communication was often via email.

### 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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: Following the changes to the GP partnership the GP partners put plans in place to work an extra session a week to ensure all medicine and long-term condition reviews were completed.	

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
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.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: The practice had an up to date business continuity plan in place.	

### 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: The new telephony system allowed the practice to monitor call activity data and respond accordingly in real time.	

### 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 involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group (PPG).	Y
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: We were informed that the practice were working with the local Primary Care Network (PCN) and Integrated Care Board (ICB) to ensure there were adequate primary care services within the area.	

### Feedback from Patient Participation Group

Feedback
Feedback from the PPG was positive. Meetings were held every 2 months which were attended by the practice manager. The PPG reported they felt listened to and patient feedback regarding access and appointments were discussed with the practice informing the PPG of actions taken.

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice used significant events, audits and complaints to identify areas of learning and improvement.	

### Examples of continuous learning and improvement

The practice were working to become a training practice.
The practice had recruited 2 community nurses to support local care homes. They had introduced a system of remote patient monitoring with the local care homes. This allowed the care homes to enter observations of their residents and the practice to make plans to respond accordingly.

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

#### **Glossary of terms used in the data.**

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