

# Care Quality Commission

## Inspection Evidence Table

The Old Dispensary

(1-6621329120)

Inspection Date: 22-30 August 2023

Date of data download: 29/06/2023

## Overall rating: Good

At this inspection, we found that those areas previously rated as inadequate or requires improvement showed significant improvement and were now rated as good. The previous enforcement actions of 2 warning notices and urgent conditions have been met.

### Safe

### Rating: Good

At the last inspection in November 2022, we rated the practice as inadequate for providing safe services because:

- Although the provider demonstrated some improvements, the newly implemented systems and processes required further embedding to ensure all patients received the appropriate reviews and treatments to meet their needs. Clear clinical oversight was needed to ensure all systems were fully completed and all aspects of patient reviews were completed, including medicine reviews and reviews of patients with long term conditions.

At this inspection, we found that areas previously regarded as inadequate had been reviewed, updated, and embedded throughout the practice. Therefore, the practice is now rated good for providing safe services.

- The practice had clear systems, and processes to keep people safe and safeguarded from abuse. There were adequate systems to assess, monitor and manage risks to patient safety.
- Appropriate standards of cleanliness and hygiene were met.
- Staff had the information they needed to deliver safe care and treatment.
- The practice had systems and oversight for the appropriate and safe use of medicines, including medicines optimisation.
- The practice learned and made improvements when things went wrong.

## 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
<ul style="list-style-type: none"><li>Safeguarding policies were available to staff, which included how to recognise signs of abuse and what action should be taken. The policies included consideration of safeguarding the wider families involved and for the change from child to adult safeguarding.</li><li>The practice had a named safeguarding lead to provide advice and support to staff if needed. Staff told us that GPs and nursing staff were trained to safeguarding level 3 and reception and admin staff to safeguarding level 2.</li><li>Safeguarding registers were maintained for adults and children involved in the safeguarding process. Safeguarding review meetings for adults and children were held on alternate months. Safeguarding Childrens meetings were held every 1-2 months and were attended by the health visitor. Meetings were recorded to ensure an audit trail of discussion and any actions needed.</li></ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	NA
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<ul style="list-style-type: none"><li>There had not been any staff recruited since the last inspection. We inspected recruitment processes at our previous inspections and had no concerns.</li></ul>	

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: 17/08/2023	Y
Actions from fire risk assessment were identified and completed.	Y
<ul style="list-style-type: none"> <li>Environmental risk assessments were recorded for all aspects of the premises and actions taken to action any areas identified. Fire alarm and emergency lighting tests were completed weekly by staff and recorded to ensure a clear audit trail of actions taken.</li> <li>A risk assessment of the service security had been completed, and systems were in place to ensure safe access and security for staff and patients.</li> <li>Staff had access to a panic alert system in each room in the instance of an emergency or dangerous situation with a patient. Reception staff alarms were linked to an external security control room and portable alarms were also available.</li> </ul>	

## 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: June 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
<ul style="list-style-type: none"> <li>The practice is located in an older building. The practice had an Infection Prevention Control (IPC) policy, risk assessment and checklist, which was last completed in June 2023.</li> <li>There was an infection prevention control (IPC) lead nurse and an administration staff member who had completed the required training. Protected time was allocated each Friday to review any IPC risks. They provided lunchtime updates for staff on any changes or relevant IPC information.</li> <li>We observed that staff took measures to reduce the risk of COVID-19 infection. For example, we saw staff wore PPE where needed and alcohol gel was located throughout the building with signage reminding people to use the hand gel.</li> <li>Clinical waste disposal was available in clinic rooms. All sharps' boxes were dated and signed when first in use and again when ready for disposal; This enabled an audit trail of their use. Clinical waste was stored securely until collected.</li> <li>An external cleaning service was used which, as part of their contract adhered to COSHH regulations for the safe storage of cleaning solutions. Hazard sheets were available to staff if needed. Cleaning staff attended daily.</li> </ul>	

## 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
<ul style="list-style-type: none"><li>Staffing levels were planned to ensure there was enough coverage for periods of leave such as annual leave or to cover sickness.</li><li>Reception staff had access to a duty GP or nurse if they had concerns about the wellbeing of patients waiting in reception or on a telephone call.</li><li>Staff were provided with training in basic life support and how to deal with medical emergencies. There were signage and flow charts to inform staff of actions to take in an emergency.</li></ul>	

## 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
<ul style="list-style-type: none"><li>The previous enforcement actions taken by CQC had prevented the registration of any new patients. All new patients would be registered with the merger practice, The Quarter Jack Surgery. A registration form would be completed, and a medicines and medical history reviews carried out by a nurse. Patients were</li></ul>	

booked to see a GP if necessary for example, those patients with a long term condition or taking complex medicines.

- There was a summarising process in place which required staff to update the electronic record system with the patient's historical records. The merger practice completed this process.
- The practice had a system to manage test results and ensure the clinical oversight of the tests. If the requesting GP was not available to review the results, the duty GP looked at all results and actioned if necessary. We reviewed the electronic record of test results and saw that results were seen in a timely manner with no results waiting an extended time.
- A register was maintained of all urgent and fast track referrals to the hospital. An administrator ensured each case was seen before removing them from the list. If the referral was not picked up by the hospital, the administrator would contact the relevant department.

## 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)	0.99	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)	10.0%	8.3%	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)	5.80	5.16	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	81.7‰	105.4‰	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)	0.39	0.55	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	3.5‰	7.3‰	6.8‰	Tending towards variation (positive)

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.	NA
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.	NA
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
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	NA
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.	NA
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
<ul style="list-style-type: none"> <li>The provider was able to demonstrate that there were safe systems to prescribe medicines to patients where specific, frequent monitoring was required. The remote clinical searches of electronic patient records showed that reviews of coding of illness were underway with some patients records still being reviewed to ensure they accurately reflect the patient's health conditions and current prescriptions. This was an extensive piece of work being undertaken during reviews, patient appointments, and ongoing monitoring. with timescales for completion.</li> <li>The clinical searches undertaken as part of the inspection showed that 22 patients were prescribed DMARD medicines Methotrexate and Azathioprine (used to treat rheumatoid arthritis), and all had received appropriate monitoring.</li> </ul>	

- The clinical searches undertaken showed that for 2 patients being treated with Lithium, a mood stabilising medicine, monitoring had been completed.
- The clinical searches undertaken showed that for the 13 patients being treated with aldosterone antagonist (used to treat heart problems), monitoring had been completed, but 1 patient was not correctly coded. The practice told us this is due to be picked up at their annual review which was due the following month. Identifying that the newly implemented systems were effective.
- The clinical searches showed patients prescribed Gabapentin (used to treat epilepsy and some nerve pain,) had all been satisfactorily managed.
- The clinical searches undertaken showed 334 patients were being treated with ACE inhibitors or receptor blockers for the treatment of high blood pressure, heart failure and strokes. Of these 24 patients had not yet received the monitoring needed but had been identified and would be seen as part on an ongoing review process. We reviewed 5 patients records and saw that while monitoring was ongoing there were some coding issues to ensure consistent oversight was maintained. The practice was aware of the need to constantly review records to update and correct coding and estimated that with the current review programme, by April 2024 all records would have been reviewed and corrected.
- Our clinical searches looked at patients over 70 years who were prescribed Non-Steroidal Anti-Inflammatory medicine and or antiplatelet medicines. We were looking to see if any patients had not been prescribed a PPI medicine needed to protect the patients' stomach. We saw that there were 43 patients who had not been prescribed the PPI medicines. Prior to the inspection, the practice had undertaken a review of this patient group and had identified that some patients needed to be reviewed. The systems implemented meant that this risk group would all be reviewed as part of a scheduled system of working which ensured risks were prioritised and appropriate action taken in a timely way.
- Our clinical searches identified 3 patients with low haemoglobin (used to carry oxygen around the blood) who had not been coded to highlight this. The patients had been seen and investigated, and no further action was needed. The coding has subsequently been updated.
- A recent backlog of medicine reviews had been completed by a clinical pharmacy team, and a new system of reviews was underway.
- Primary Care Network (PCN) Co-ordinators carry out regular records searches for patients who are due a Standard Medicine Review (SMR). They then contact the patient to book them in directly with PCN pharmacists to carry out the review. The practice also checked that reviews were completed and followed up any non-responders or attenders.
- Medicine reviews were ongoing. The remote searches identified 69 patients who had received a medicine review in the last 3 months. The medicines reviews we saw were of good quality with sufficient detail and inclusion of the patient when needed.
- Medication reviews were a standard process during a chronic disease review, this combined with supportive data such as blood results, diagnostic tests and clinical notes provided an overview of each patient for their clinical medication review.
- The practice had a prescribing lead who worked with the prescribing clerks handling repeat prescribing and worked closely with the PCN appointed prescribing team.
- Since our last inspection, prescription audits had been implemented and changes made as a result. Controlled drug prescribing had been reviewed with a newly implemented system of patient contact, re-setting prescribing parameters and reviewing usage to prevent over prescribing.
- Asthma prescribing of inhalers had been reviewed and amendments to prescribing made to reduce over prescribing.
- Antibiotic prescribing rates were identified as higher than the national average. Clinical staff promoted reduced prescribing with patient education and alternative management strategies.
- National prescribing data was planned to be analysed over the subsequent 3- and 6-month periods to measure change.



- A repeat prescribing protocol was introduced in August 2023, which enabled patients to request and receive medication or other prescribed treatments without having a consultation with a GP or a nurse. The protocol identified which medicines needed special monitoring or were high risk drugs so that staff could easily recognise if a review was needed or the patient needed contacting to book a relevant appointment.
- Medication changes from hospital letters and discharge summaries were reviewed by the patient's GP and the PCN pharmacist. Medicines reconciliation would then be made by suitably trained/authorised staff (including clinical pharmacists, pharmacy technicians, prescribing clerks and GPs' personal assistants) as a matter of routine.
- MHRA email alerts went to the GP and pharmacist to ensure prompt action within 48 hours. Information was then cascaded to staff.

### 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: 3	Y
Number of events that required action: 3	Y
Explanation of any answers and additional evidence:	

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

Event	Specific action taken
<ul style="list-style-type: none"> <li>• Wrong dressing used on wound.</li> </ul>	<ul style="list-style-type: none"> <li>• The appropriate remedial action was taken to prevent any future recurrence. The event was discussed at nurses' meetings to ensure wider learning.</li> </ul>
<ul style="list-style-type: none"> <li>• Delivered fridge medicines were not transferred to a fridge in a timely way and so not usable.</li> </ul>	<ul style="list-style-type: none"> <li>• The incident was discussed at the staff meeting and GPs meeting, and learning was taken. Systems were implemented to prevent this from happening again.</li> </ul>

Safety alerts	Y/N/Partial
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There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<ul style="list-style-type: none"> <li>• The provider was able to demonstrate that safety alerts were reviewed had been responded to.</li> <li>• Medicines and Healthcare products Regulatory Agency (MHRA) email alerts went to the GP and pharmacist to ensure prompt action within 48 hours. Information was then cascaded to staff. For example, the MHRA had introduced safety measures recommending Sodium Valproate (a medicine used to treat epilepsy) must no longer be prescribed to women and girls of childbearing age unless they were on a pregnancy prevention programme and highly effective contraception. Our searches showed that for 1 patient, records did not evidence the patient had been assessed as at risk. Following the remote searches, the practice provided assurance that the information had been provided at a hospital appointment; they ensured records were updated and coding was corrected to ensure searches and clinical review would be prompted.</li> <li>• The MHRA alert against the concurrent use of Clopidogrel (used to treat heart conditions) and Omeprazole/Esomeprazole (used to treat some gastric problems). Our remote searches showed no patients were being prescribed this combination.</li> </ul>	

## Effective Improvement

## Rating: Requires

At the last inspection in November 2022, we rated the practice as inadequate for providing effective services because:

- New systems and processes required further embedding to ensure all patients received appropriate reviews and treatment to meet their needs. Clear clinical oversight was needed to ensure all systems were fully implemented and all aspects of patient reviews were completed.
- There was limited monitoring of the outcomes of care and treatment. Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.
- The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

At this inspection we recognised the work undertaken to meet the enforcement actions and will continue to monitor the areas of effective that require further embedding The practice is therefore now rated requires improvement for providing effective services.

- Systems were embedded to ensure clinical oversight of appropriate reviews and treatment to meet patients' needs.
- 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.
- The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.
- Staff worked with other organisations to deliver effective care and treatment.
- Staff were consistent and proactive in helping patients to live healthier lives.
- The practice always obtained consent to care and treatment in line with legislation and guidance.

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

### **Effective needs assessment, care and treatment**

**Patients' needs were 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.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
<ul style="list-style-type: none"> <li>• The National Institute for Health and Care Excellence (NICE) compliance guidelines and any updates or changes in practice were discussed when needed. This meant staff were kept up to date with changes in good practice.</li> <li>• Patients were having their immediate and ongoing needs assessed and reviewed to ensure clear and accurate was maintained. Patients with ongoing conditions were monitored and reviewed, including a review of their medicines. Patients presenting with new symptoms were reviewed in a timely way and were referred when needed and followed up at the practice.</li> <li>• The practice audited outcomes to ensure they were confident of the service provided. For example, staff undertaking cervical screening audited their own practice, looking at success rates and any feedback. Nurse prescribers audited their own prescribing with support from the medical staff.</li> </ul>	

## Effective care for the practice population

### Findings

- Those identified received a full assessment of their physical, mental and social needs. The process was ongoing over the year to ensure all patients were reviewed and patients were invited on a timescale associated with their birth month.
- Health checks, including frailty assessments, were offered to patients over 75 years of age and ongoing frailty reviews by the frailty nurse practitioner and a dementia care plan implemented.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- Well man and well woman assessments were available. There was an appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. Flu, shingles and pneumonia vaccinations were offered to relevant patients.
- All patients with a learning disability were offered an annual health check by the learning disability lead nurse.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. There were strong links with the community palliative care team to ensure ongoing multidisciplinary support for patients at the end of life.
- The practice demonstrated that they had a system to identify people who misused substances. The PCN pharmacist was available to support patients who wished to reduce any medicines which may be prone to addiction.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The practice had access to a mental health nurse and a social prescriber to support vulnerable people in the community.

## Management of people with long term conditions

### Findings

- Patients with long term conditions were offered an effective annual review to check their health and medicines needs were being met. Staff who were responsible for reviews of patients with long term conditions had received specialist training and were experienced in their specific area.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. For example, we saw evidence patients with chronic kidney disease were appropriately monitored and reviewed.
- There was a rolling programme of chronic disease clinics (based on prevalence and searches) delivered by skilled chronic disease nurses. The Old Dispensary site now hosted predominantly nurse activity with phlebotomy and PCN services utilising the rooms and a few GP sessions available.
- As part of our remote searches, we saw that the practice had 125 patients with hypothyroidism, which is an underactive thyroid gland. All 125 patients had been appropriately reviewed.
- As part of our remote searches, we saw 1 blood test result indicating the patient may have a potential missed diagnosis of diabetes which had not been identified or recorded in their records. Following the

inspection, we were advised that the patient now has an appointment to see the GP to discuss the results.

- Our remote searches showed patients who required 2 or more courses of high dose oral steroid treatment for exacerbations of asthma in the last 12 months were not always followed up to ensure they received appropriate care. Systems were not yet fully embedded to ensure patients were followed up post exacerbation of asthma, to ensure review of their condition and medicines. Our remote searches identified 11 patients who had been prescribed 2 or more courses of high dose oral steroids. We looked at 5 patient records and saw that not all patients had received adequate assessment at the time of prescribing or after the oral steroids. We saw that steroid cards had not been issued. The practice told us at the time of the site visit that these patients had been followed up and the use of steroid cards was now being promoted as part of the asthma review policy.
- The asthma risk register had 156 patients, and 51 of those patients had been seen at the asthma clinic since April 2023. The ongoing review of asthma patients was risk prioritised using a clear set of criteria for example, patients who had 2 or more courses of steroids, had over 12 prescribed inhalers in a year or who had not had a review in the last 12 months. This risk criteria enabled the higher risk patients to be seen first. All patients with asthma would be seen for a review by April 2024.
- Asthma and COPD clinics were using structured templates with an emphasis on prevention, safe prescribing and care plans. Supported by a PCN led respiratory assessment clinic offering testing and spirometry to national standards. A recent review of asthma services reflected the benefits of collaboration between the prescribing team and the asthma lead, resulting in improved care and patient education.
- GPs followed up with patients who had received treatment in a hospital or through out of hours services for an acute exacerbation of asthma. The practice provided patients with leaflets to support and inform them for some long term conditions, including Asthma Inhalers – A Guide for Adults.
- The practice used a formula to demonstrate how long inhalers should last to ensure that appropriate prescribing takes place and to avoid over prescribing. Further work had been undertaken to establish how often prescribing of inhalers could be managed to prevent over prescribing. A system for monitoring had been created, which prompted an inhaler over reliance text being sent to the patients to establish the reason for more inhalers being requested. This was being used to establish an overview of good asthma control and trigger a review if needed.
- As part of our remote searches, we reviewed 21 patients with diabetic retinopathy an eye condition which can affect people with diabetes), who had a high HbA1C (a blood test to measure sugar levels) test result that showed poor control of their diabetes. We reviewed 5 patients' records and saw that they were all being monitored. The high-risk group of patients with a HbA1C greater than 74 had been targeted, with 18 out of the 22 seen, the remaining 4 had appointments pending. Routine care was now being established spread across the 6 – 12 month follow up periods. Medication review dates also triggered an appointment for a blood test, data collection and then a clinical lead appointment.
- Cardiovascular Disease routine care was delivered by a team including an HCA taking bloods and collecting clinical data, home BP monitoring, chronic disease nurses undertaking reviews, and GP care. The practice had trained staff to provide ongoing reviews of all cardiovascular care conditions as part of an ongoing programme of care.

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.	37	38	97.4%	Met 95% WHO based target

three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
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)	25	29	86.2%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	26	29	89.7%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	25	29	86.2%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	24	25	96.0%	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 followed up on childhood immunisation appointments not attended and provided support and advice for those involved in non-attendance. The practice told us that for childhood immunisation overdue/imminent, patients had been recalled, and any non-responders telephoned. Nursing appointments were available, and a 3-month audit cycle was ongoing. For those groups noted above to be below 90%, this equated to 4 children, all of which had been invited. Appointments for 2 of these children were booked.

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)	70.1%	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)	79.1%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened	77.4%	N/A	80.0%	Below 80% target

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)				
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)	62.1%	58.5%	54.9%	No statistical variation

#### Any additional evidence or comments

- The practice advised that cervical screening overdue/imminent patients had been recalled, nursing appointments were available, and there was a three-month audit cycle ongoing. The Primary Care Network had started a Saturday morning clinic for cervical smears which included patients from The Old Dispensary. The updated data provided by the service was patients aged 25-49 had 78.8% completed, and patients aged 50-64, 81.6% completed. This data could not be verified.

#### 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
<ul style="list-style-type: none"> <li>Following the CQC inspection in November 2022 the practice looked at the data searches for any patients outside of the normal scope expected for treatment with medicines and/or already identified as a risk. One of those searches with outliers was Protein Pump Inhibitor (PPI) drugs, prescribed to patients aged less than 70 years old who were also taking antiplatelet medication. PPI drugs are used for acid related disorders, and antiplatelet medicines are used to reduce the risk of abnormal blood clotting. Patients identified as needing an adjustment to their medicines were risk rated and reviewed using coded diagnosis, repeat medication, the medication history, hospital correspondence and risk factors. Using NICE guidance and West Essex Guidelines, appropriate amendments were made. Learning was taken from the audit and adjustments made to prevent any potential future missed opportunities.</li> </ul>	

#### Effective staffing

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

	Y/N/Partial
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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
<ul style="list-style-type: none"> <li>• The provider demonstrated that staff had the right qualifications, skills, knowledge and management support to deliver good quality care and treatment. The merger of 2 practices had meant the shared skills and experience benefited The Old Dispensary with an established team providing services to patients and expanding the number of appointments available.</li> <li>• Personal development was supported and encouraged with staff supported to complete online training during work hours.</li> <li>• Clinicians were required to maintain their professional registration and demonstrate their competencies when they were revalidated with the relevant professional body. The practice monitored their up-to-date registrations to ensure they were registered to practice.</li> </ul>	

## Coordinating care and treatment

### Staff worked 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
<ul style="list-style-type: none"> <li>• The practice managed patients at both locations involved in the merger and they worked together to provide patient services. Most GP appointments were at The Quarter Jack Surgery with The Old Dispensary providing a nurse hub with specialist staff providing long term conditions reviews, nurse led clinics and a small amount of GP appointments.</li> <li>• Clinicians followed up on the care and treatment of patients following referrals to external services and were involved in multi-disciplinary discussions when needed. Patients referred as part of an urgent referral were included on a list, and the administrative staff followed them up to ensure they had received an appointment and were seen as needed. As an extra precaution, patients were advised to contact the practice if they had not had a response from their referral.</li> <li>• The practice had access to a social prescriber and mental health nurse through the PCN. This enabled easier referrals and ongoing monitoring.</li> </ul>	



### 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
<ul style="list-style-type: none"><li>• The GP appointments and long term condition and medicine reviews enabled patients' health journeys, including how they were supported to live healthier lives and any outcomes or changes needed.</li><li>• Information was available on the practice website regarding action and support to live healthier lives. Patients with long term conditions could also access information and support, for example, asthma, diabetes and heart disease.</li></ul>	

### 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
<ul style="list-style-type: none"><li>• Consent was agreed verbally and appropriately recorded. Remote consultations were not used to assess capacity in adults or children and face-to-face appointments would be made.</li></ul>	

- The GPs used opportunities as they presented to ensure that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) was completed. The agreements of care were reviewed as necessary to ensure that the correct legal pathways were created to support patient choice.
- Our clinical review of notes where a DNACPR decision had been recorded identified where possible, the patients' views had been sought and respected, and we saw that information had been shared with relevant agencies. We saw 1 record where this was unclear, and the practice confirmed that contact with the patient had been made to clarify the coding and DNACPR status.
- The clinical team meet quarterly with the local palliative care community matron and consultant to discuss cases and service provision. An audit of DNAR codes every 2 months looked at supporting notes and coding to ensure comprehensive care was provided and documented.

## Responsive

## Rating: Good

At the last inspection in November 2022, we did not inspect responsive. In August 2022 we rated responsive as requires improvement because:

- Not all patient records accurately reflected care and treatment required or delivered by the practice and the practice had not actioned updates from secondary care documents. This meant that while patients could access the service, they may not have been recalled or invited to clinical care appointments in a timely way.
- Complaints were listened and responded to, however, subsequent learning was not shared or used to improve the quality of care.

At this inspection, we found that those areas previously regarded as inadequate practice were now reviewed, updated and embedded throughout the practice. The practice is therefore now rated good for providing responsive services.

- The practice organised and delivered services to meet patients' needs.
- People were able to access care and treatment in a timely way and the practice actioned updates from secondary care documents.
- Complaints were listened and responded, and the learning shared and used to improve the quality of care.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	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
<ul style="list-style-type: none"><li>• The needs of the population group had been identified, and the practice had adjusted the services it offered to ensure they were accessible, flexible and offered continuity of care. The availability of a wider range of clinics and specialist staff provided patients with further access to medical and nursing reviews.</li></ul>	

- Extended practice hours had been implemented to enable access for those patients unable to see a GP during opening hours. The practice was using the PCN provision to enable wider access to clinics, for example, extra clinics on a Saturday for cervical screening. All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability, providing a range of ways to undertake reviews, including supported practice appointments, video calls and home visits.
- People in vulnerable circumstances were easily able to register with the merger practice, including those with no fixed abode, such as homeless people and Travelers.
- Information was available to patients in large print, and a hearing loop was available for patients with hearing loss. Door signage was available in Braille.
- Translation services were available for those patients whose first language was not English and who needed further translation support.

### 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
Appointments available:	
Monday	8am - 6pm
Tuesday	8am - 6pm
Wednesday	8am - 6pm
Thursday	8am - 6pm
Friday	8am - 6pm

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

- The GP lists for all patients were currently being agreed. Patients at both locations had a 'personal list' system of care, where each patient was assigned a named specific GP. The practice used a duty GP system, which covered for a GP not available that day. Staff told us that the system worked responsively for them.
- 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 frailty nurse ensured that all parts of the frailty plan were completed in one appointment, including any dementia care plan and assessments of mental capacity to reduce the travelling and anxiety for patients.
- The practice considered the demands on the practice and the demands on the working population. The Asthma review nurse ensured that all pre-required tests were completed prior to the patient attending

the clinic to ensure that decisions and changes, if needed, could be made with the patient and avoid further appointments.

- The PCN pharmacist completed medicine reviews and, where necessary, with the specialist review nurse to ensure that any queries or questions could be reviewed and managed responsively.

## Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<ul style="list-style-type: none"> <li>• The merger of The Old Dispensary with The Quarter Jack Surgery meant more GP and nurse led clinic appointments were made available across the 2 locations to minimise the length of time patients had to wait for appointments and to enable specialist nurse reviews to be available.</li> <li>• Each week across the 2 locations, there were up to: 1,130 GP and Advanced Nurse Practitioner appointments 480 practice nurse and HCA appointments 200 phlebotomy appointments 20 chronic condition clinics (cardiac, respiratory, diabetes, frailty)</li> <li>• The website for The Old Dispensary provided information on how to make an appointment. There was a range of appointment bookings, including telephone calls to book and online electronic booking. This enabled patients with any communication needs to access an appointment.</li> <li>• Patients assessed as having the highest needs were prioritised. During the site visit, we reviewed the availability of GP and nurse appointments and saw that there was availability for priority or urgent patients for both on the day of inspection and the following days.</li> </ul>	

## 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
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The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	100.0%	N/A	52.7%	Significant variation (positive)
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)	98.5%	65.2%	56.2%	Significant variation (positive)
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)	86.4%	61.8%	55.2%	Variation (positive)
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)	95.2%	77.6%	71.9%	Variation (positive)

#### Any additional evidence or comments

- The Old Dispensary scored positively with the National GP Survey. The NHS GP Patient Survey 2023 showed that of the 237 surveys sent out, 105 surveys were returned. These showed that 83% of respondents had a good or fairly good experience of making an appointment. This is compared to the national average of 54%.
- The surveys showed that 89% of responses found getting through to the practice by telephone was easy. This is compared to the 49% national response.
- The surveys showed 99% of responses found reception staff to be fairly or very helpful, compared to the national result of 82%.
- The remaining scores around satisfaction with GP appointment times, choice of appointment and satisfaction with the appointment including the patients' needs being met, all exceeded the national results.

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were no reviews available on this website.

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

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
The practice received a complaint about the management of care and treatment.	The concerns were treated as a significant event and managed by a face-to-face meeting where the issues were discussed and a suitable outcome met. Learning was taken forward, and changes in practice were made.

## Well-led

## Rating: Good

At the last inspection in November 2022, we rated the practice as inadequate for providing well led services because:

- New systems and processes required further embedding to ensure all patients received the appropriate reviews and treatment to meet their needs.
- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- The overall governance arrangements required more clinical oversight and support to ensure they were developed to be effective.
- The practice did not have embedded and effective processes for managing risks, issues and performance.

At this inspection, we found that those areas previously regarded as inadequate practice were now reviewed, updated and embedded throughout the practice. The practice is, therefore, now rated good for providing well led services.

- There was compassionate, inclusive and effective leadership at all levels and a culture which drove high quality sustainable care.
- The practice had a clear vision and credible strategy to provide high quality sustainable care.
- There were clear responsibilities, roles and systems of accountability to support good clinical oversight, governance and management and effective processes for managing risks, issues and performance.
- The new systems and processes had been implemented to ensure all patients received the appropriate reviews and treatment to meet their needs.
- There was a demonstrated commitment to using data and information proactively to drive and support decision making.
- The practice involved the public, staff and external partners to sustain high quality and sustainable care with systems and processes for learning, continuous improvement and innovation.



## 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
<ul style="list-style-type: none"><li>• The management team were forward-thinking in the growth, development and sustained success of the merged GP practices. Partners held managerial and financial responsibility for running the business, and there was a system of leadership, development and succession planning. The staff we spoke with described inclusive and effective leadership at all levels. Staff said they felt supported by the practice partners and management and described an inclusive working environment which supported them to develop in their roles.</li><li>• The senior management team understood the issues, challenges and priorities of the service and gave examples of increased capacity requirements and how this demand was met. The provider told us they had adapted the medical and nursing workforce allocation and location to enable the sustainability of the service.</li><li>• There was a business development plan for the ongoing running and development of the service. The management of the service demonstrated a clear understanding of what was required to manage the challenges to quality and diversity of services.</li><li>• There was clear clinical oversight and management strategies for potential risks to the patients and the practice. The provider had clear management and staffing structures in place, so people understood their roles and responsibilities. Staff were allocated leadership roles, which included infection prevention and control, safeguarding and clinical and non-clinical leads.</li></ul>	

## 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
<ul style="list-style-type: none"><li>• Staff were aware of the provider's vision and felt involved in its development. The objectives identified by the practice were underpinned by a strategy to achieve them. They considered the objectives to be challenging but achievable. The strategies were aligned with plans for the wider health economy and</li></ul>	

there was a commitment to system-wide collaboration to support service development and the success of the merger.

- There was a systematic and integrated approach to monitoring and plans for the ongoing practice development were reviewed as part of operational meetings and staff appraisals.

## 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
<ul style="list-style-type: none"> <li>• There were varying levels of satisfaction across staff we spoke to, depending on their role and the impact of the merger. All staff we spoke with were proud of the organisation as a place to work and mostly told us they felt valued, included, and involved in the practice.</li> <li>• Staff described how they could raise concerns and felt safe to do so. The practice had systems to support the wellbeing and welfare of staff. The practice could access a Freedom to Speak Up Guardian, and the practice manager operated an open-door policy. Staff told us they felt able to raise any issues.</li> <li>• We asked staff to complete a Care Quality Commission (CQC) survey prior to our inspection, and 3 staff completed these. Staff spoke positively about working at the practice but had struggled with the changes being implemented.</li> </ul>	

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

Source	Feedback
CQC staff questionnaires	The theme noted was that staff found the changes difficult and there had been positive and negatives to the ongoing process.

## 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
<ul style="list-style-type: none"> <li>• The merger prompted a programme of continuous clinical assessment and internal auditing, which was used to monitor quality and to make improvements. The GPs met each Friday to discuss any issues and consider developments. There were routine clinical and practice meetings for medical and nursing staff to support the open discussion of issues and cascade learning. Minutes of the meetings were maintained and accessible to relevant staff. Administrative and reception staff met regularly, and minutes recorded the areas discussed and included areas of concern, challenges and plans.</li> <li>• Governance also included complaints and significant events, which were monitored. We saw that each complaint was reviewed and that appropriate actions were taken. Incidents were monitored to identify any shortfalls in service provision and ensure action and learning.</li> <li>• The governance structure for the practice included changes being communicated through operational meetings, emails and group discussions. The communication was extended to third parties as needed, for example, health professionals and secondary care providers.</li> <li>• Staff had identified lead roles, for example, safeguarding and infection control. Staff were clear about the roles and their own roles and responsibilities.</li> <li>• The provider was proactive and responsive to any concerns raised. As part of the inspection, remote searches showed that a very small amount of monitoring had not yet been completed. By the time we completed the onsite element of the inspection, identified shortfalls had already been addressed, and systems were further embedded to prevent future recurrence.</li> </ul>	

### 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
<ul style="list-style-type: none"> <li>• There were systems at the practice for reviewing best practices and monitoring of risk. Risk registers were used to maintain oversight and manage delegation of tasks and timescale for follow up.</li> <li>• Risk assessments were used to monitor and mitigate against any identified risks. Risks were discussed at practice meetings to review actions taken to prevent reoccurrence.</li> </ul>	

- Assurance systems included monitoring of the services provided. For example, there was oversight of medication practices, long term condition reviews and infection control procedures. Staff had received appropriate training and monitoring to lead on responsibilities about risk oversight.
- A major incident plan was in place, and staff were aware of actions to take in the event of any interruption to the service.

#### 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
<ul style="list-style-type: none"> <li>• Document handling had been integrated between the 2 merged practices. Letters were 'actioned', which involved uploading the document, a data coder reviewed the information and ensured new and significant codes were added, any new medicines or changes to the regimes were enacted by the prescribing teams, and finally, the GP was given the document for information and further clinical action.</li> <li>• At the time of our remote searches, there were 41 documents awaiting processing, with the oldest being within a reasonable timescale.</li> </ul>	

#### 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

- Information was provided for patients on the practice website on how their personal details were stored securely and how their privacy was maintained. The website detailed how personal data was gathered and what that data would be used for.
- All electronic equipment was password protected, and the reception area faced away from patients. Patient data were stored securely where it was on site, and other records were stored securely at the merger practice.
- Consent or agreement was obtained from the patient and recorded to identify their preferred contact method.

### 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
<ul style="list-style-type: none"> <li>• The Old Dispensary PPG had not been reconvened post Covid. An action had been taken to include a PPG invitation into the patient letters used when informing patients of their allocated GP. There was a planned meeting by The Quarter Jack Surgery PPG to include The Old Dispensary PPG and hopefully to promote new membership.</li> </ul>	

### Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> <li>• We spoke with the chairperson for the PPG and heard about the scope of the role and the development of the PPG to include further patient feedback. The meeting shortly after the inspection was expected to bring together the 2 PPG groups and promote a sustainable patient voice.</li> </ul>

### 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
<ul style="list-style-type: none"> <li>There had been significant learning and development of systems to support the practice. Following the merger of The Old Dispensary with The Quarter Jack Surgery there was a strong emphasis on restructure and learning to ensure the success of the merger. Learning and review was used to progress the services to meet the needs of the patients and local health landscape. We saw from our ongoing monitoring and the inspection that there had been a significant amount of work undertaken and we were told this continuous learning and development was ongoing.</li> </ul>	

### Examples of continuous learning and improvement

<ul style="list-style-type: none"> <li>The practice had signed up to use 'C Signs', a palliative care support tool to facilitate referrals, clinical decision making, and auditable data intended to drive early cancer detection. The GP lead had done the training in preparation for the release date.</li> <li>Visiting speakers were invited to the GP meetings. The pharmacy services visited the GP meeting to speak about pharmacy services to support ongoing learning and development and the mental health practitioner recently attended to discuss their role.</li> <li>The practice supported medical students' involvement in clinical audit. A recent presentation by medical students looking at DOAC renal function monitoring had been presented at the GP business meeting to promote learning and improve patient services.</li> </ul>
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### 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)	≥3
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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.