

Inspection Evidence Table

The Broadway Surgery

(1-5021022741)

Inspection Date: 30 May and 6 June 2023

Date of data download: 25 May 2023

Overall rating: Requires Improvement

We have rated the practice as requires improvement overall because:

- The practice did not have clear systems, practices and processes to keep people safe.
- Risks to patients, staff and visitors were not always assessed, monitored or managed effectively.
- The practice did not always have systems for the appropriate and safe use of medicines.
- Safety alerts were not managed effectively and prescribing relating to these did not keep patients safe.
- The system to identify and manage delays in referrals was ineffective.
- The practice leaders had not assured themselves that all staff had the skills, knowledge and experience to carry out their roles.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not have clear and effective processes for learning from significant events and complaints and records relating to these were not always maintained.
- The overall governance arrangements were ineffective.

Safe

Rating: Requires Improvement

We have rated the practice as requires improvement for providing safe services. This is because:

- Risks to patients, staff and visitors were not always assessed, monitored or managed effectively.
- The practice did not always maintain complete records for each patient.
- There were concerns around medicines management, such as the monitoring and prescribing of some medicines, including those medicines that require monitoring.
- Safety alerts were not managed effectively and prescribing relating to these did not keep patients safe.
- The system to identify and manage delays in referrals was ineffective.
- There was limited assurance that actions from health and safety risk assessments had been completed.
- There was little evidence that all incidents, concerns, or near misses were consistently recorded and that opportunities for learning and quality improvement were identified.
- There were gaps in recruitment records for locum staff.
- There were gaps in mandatory training completion records.

Safety systems and processes

Systems, practices and processes to keep people safe and safeguarded from abuse were not always effective.

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:</p> <p>The GP and safeguarding administrator met regularly to review the safeguarding registers and follow up patients where there were safeguarding concerns. Minutes of meetings included evidence of liaison with health visitors, including when children were not brought to an appointment. There were clear processes in place to protect patients at risk of potential harm.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were no references for a locum GP working in the practice.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment: 21 March 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: October 2021	Y

Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>A fire risk assessment had actions that were the responsibility of the landlord and actions that were the responsibility of the tenant. The practice staff were unsure what had been completed and there was no record of this, so there was limited practice oversight.</p> <p>A fire evacuation drill had been carried out by the landlord in November 2022. Actions to improve as a result included services within the building having more designated fire wardens and that suitable high visibility uniforms needed to be worn. Practice staff were unsure if this had been actioned, although the practice manager told us they were a designated fire warden.</p> <p>A March 2023 health and safety risk assessment identified risks in relation to areas such as fire safety, electrical risks, falls and moving and handling. However, the assessment was not comprehensive and actions were not specific and were referenced as ongoing.</p> <p>The practice was unable to show us a legionella risk assessment at the time of our visit and told us the responsibilities for this did not sit with the practice. They later forwarded premises information to us which included a 2022 legionella risk assessment. The risk assessment showed a medium risk and included actions such as ensuring water temperature monitoring and identification / flushing of infrequently used water outlets. Staff within the practice were unsure if these actions had been completed and were unable to provide us with evidence these issues had been addressed. We requested evidence of water temperature monitoring, but this was not provided.</p> <p>An electrical installation condition report from 2020 showed the installation as unsatisfactory, the practice was unable to provide evidence of actions to address this at the time of the inspection.</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.	Partial
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 01/02/2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Most staff had completed infection control training, however, there was no infection control training record available for the principal GP or the locum GP. This had not been identified on the infection control audit.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Most staff had a record of a completed induction when commencing in post. However, records relating to a locum GP and a volunteer did not include evidence of a completed induction. In addition, we saw an induction record for one member of the clinical team that included a record of a review that was due to be undertaken at the end of the first 4 weeks after commencing in post, however, this was signed as complete on the first day of their induction.</p> <p>The practice had appropriate emergency equipment in place, and this was checked regularly by staff. However, there was no record of reception staff having completed training in awareness of suspected sepsis. In addition, the practice had records to demonstrate that all staff had completed training in cardiopulmonary resuscitation in the last 12 months through online refresher training. However, we were told that clinical staff had not undertaken practical basic life support training that included an assessment of their practice in the since 2019. We were told the practice were sourcing this training and aimed to have it completed during the summer.</p>	

Information to deliver safe care and treatment

Staff did not always have 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.	Partial
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.	No
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

Explanation of any answers and additional evidence:

Patient records were stored securely within the practice. However, our review of patient records in relation to the clinical searches identified that care records were not written or managed in a way to protect patients. For example, history, examination, management plans, safety netting and follow up were not adequately documented within the patient record. Our clinical searches identified 13 patients with diabetic retinopathy and high blood glucose levels, we reviewed the records of 5 of the patients and found a lack of recorded follow up in their patient record. Our clinical searches identified 14 patients who had received 2 or more doses of oral steroids in the last year. We reviewed the records of 5 of these patients found there were insufficient records to demonstrate appropriate follow up and records of assessment were not comprehensive. In addition, our searches identified 10 patients with a potential missed diagnosis of chronic kidney disease. We reviewed the records of 5 of these patients and found that they were not appropriately coded which meant there was a risk of insufficient follow up. Patient records did not always include sufficient detail in relation to their consultation or the advice given. This had a potential to impact information shared with other services and clinicians accessing the patient record.

There was not an adequate system to monitor delays in referrals. For example, we found that monitoring of 2 week wait referrals for potential cancer was insufficient. The process for checking did not include whether the patient had received an appointment or had attended an appointment. This was despite an incident relating to a delayed referral that was highlighted to the practice as a result of a complaint from the patient.

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	1.77	0.71	0.86	Significant variation (negative)
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). (01/01/2022 to 31/12/2022) (NHSBSA)	10.5%	9.3%	8.1%	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 (01/07/2022 to 31/12/2022) (NHSBSA)	7.05	5.33	5.24	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	454.2‰	158.2‰	130.3‰	Significant variation (negative)

Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	1.25	0.89	0.56	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	9.5‰	10.4‰	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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial 1
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.	Partial 2
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial 3
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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	N 4
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence, including from clinical searches.	

1.2. The provider recorded medicine reviews had been conducted, however, the documentation of outcomes from the reviews was inconsistent and there was evidence that required monitoring or potential changes to treatment had not been identified as expected during a comprehensive review. We looked at 5 medication reviews and found that 4 out of 5 did not include a review of all medicines prescribed. In addition, our clinical searches identified 124 patients prescribed long term gabapentinoids (used to treat neuropathic pain) who had not had a review in the last 12 months. Our review of patient records found that 3 of the 5 patients records we reviewed showed their medicines review did not include a review of their gabapentin use. Our review of records of patients prescribed thyroxine (to keep the thyroid hormone level within normal limits) where a medicine review had been carried out, identified 3 patients where overdue blood test monitoring had not been picked up as part of the review.

3. As part of our inspection, a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. The records of patients prescribed certain medicines that require monitoring were checked to ensure the required monitoring was taking place.

- The records we examined provided evidence that patients prescribed Disease-modifying antirheumatic drugs (DMARDs) had been monitored appropriately. Our clinical searches identified 6 patients who had been appropriately monitored. DMARDs are prescribed to suppress inflammation and help to prevent joint damage for patients with rheumatoid arthritis.
- Our search of patients on an ACE inhibitor or Angiotensin II receptor blocker (to treat high blood pressure) identified 72 out of 309 patients who did not have the required annual monitoring in line with British National Formulary guidance. We sampled 5 patient records and found 2 patients who had been prescribed these medicines when it was unclear it was safe to do so as their blood monitoring was overdue by more than a year.

4. Antibiotic prescribing was significantly higher than local and national averages. The practice had not taken action to review and reduce antibiotic prescribing to ensure this was optimised.

Practice performance indicators for pregabalin and gabapentin prescribing (used to treat neuropathic pain) were significantly higher than local and national averages. Our clinical searches identified 124 patients prescribed gabapentinoids who were receiving them long term without evidence of review. We reviewed the records of 5 patients prescribed gabapentin and found in 3 cases that medication reviews did not include a review of their gabapentin prescription. The GP told us they had plans to undertake a project to look at reducing prescribing with support from the local primary care network medicines team in the coming weeks. They told us they had prioritised a quality improvement project to look at reducing dependency forming medicines such as opiates. We reviewed the evidence of this and saw they had successfully reduced opiate prescribing by 20%.

Track record on safety and lessons learned and improvements made

The practice did not have an effective system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	No
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial

Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	4
Number of events that required action:	4
Explanation of any answers and additional evidence:	
<p>Not all incidents were appropriately recorded as significant events. For example, we saw a complaint from a patient about a delay in receiving an appointment for a 2 week wait referral for potential cancer. The practice followed up the complaint and identified an issue with the referral not having been sent. They addressed the concerns for the individual patient and liaised with the relevant clinic within secondary care, ensuring an appointment was offered at the earliest opportunity. However, there was no investigation as to the cause of the delay in the referral system and no changes made to the monitoring of referrals to ensure that learning from the incident was used to make improvements.</p> <p>Records relating to the investigations of incidents and significant events were not routinely maintained, this included, in relation to follow up and learning and dissemination. One incident relating to follow up from an incident relating to a local NHS laboratory error did not have an associated record to indicate the incident had been appropriately followed up by the practice. An incident relating to an unregistered patient had an associated action to shared information with staff, however, staff told us the issue had not been discussed and there was no record to indicate that it had been.</p>	

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

Event	Specific action taken
A request from the local NHS laboratory to review patients potentially affected by an error within the lab that may give risk to potentially inconsistent biochemistry results had been received.	We saw an email from the practice manager to clinical staff requesting that action be taken to identify potentially affected patients. However, there was no record to indicate that this had been done.
An incident relating to a blood test being undertaken for an unregistered patient.	The record of the incident included that staff needed to be reminded to register patients as a temporary resident. However, there was no evidence that this had been discussed. Staff told us this issue had not been discussed in staff meetings.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	No
Explanation of any answers and additional evidence:	
<p>The provider was unable to demonstrate that all relevant safety alerts had been responded to. We saw that patients remained on combinations of medicines that increased their risk of heart problems without anything in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered. For example, we found that 3 patients were prescribed a combination of medicines</p>	

subject to a 2014 MHRA (Medicines and Healthcare products Regulatory Agency) alert where one medicine decreased the effectiveness of the other, leading to an increased risk of heart attack or stroke. We found 2 patients were prescribed a combination of medicines where a 2014 MHRA alert warned of the increased risk of muscle pain / damage.

We reviewed the records of 5 patients out of 14 who had received 2 or more prescriptions of emergency oral steroids for acute exacerbation of asthma in the last 12 months. None of these patients had been issued with emergency steroid cards in line with a 2020 NHS England and NHS Improvement National Patient Safety Alert (NPSA).

The system for managing and acting on safety alerts was insufficient. We were told that all clinicians received emails of safety alerts and that a spreadsheet was used to capture safety alerts received. However, the system did not include evidence of all relevant safety alerts and there was no accompanying record of relevant actions taken to manage risks.

Effective

Rating: Requires Improvement

We have rated the practice as requires improvement for providing effective services. This is because:

- Patients with a long-term condition had not all received appropriate monitoring and clinical review.
- Patients' needs were not adequately assessed, and care and treatment was not delivered in line with evidence based guidance.
- Training records did not sufficiently demonstrate that staff had completed training in all relevant areas.
- Follow up for patients who had been referred to specialist services was limited.
- There was limited evidence of quality improvement activity.

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

Effective needs assessment, care and treatment

Patients' needs were not always adequately 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.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	No
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y

Patients' treatment was regularly reviewed and updated. ³	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Partial
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Partial
The practice prioritised care for their most clinically vulnerable patients.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice could not demonstrate that guidelines were consistently followed or monitored. On reviewing a sample of patients' records we found evidence based guidance had not always been followed. This included in relation to patients prescribed medicines that require monitoring not receiving the appropriate monitoring and patients with asthma not being followed up within 48 hours of an acute exacerbation. • 1 Assessments of patients' immediate and ongoing needs were not recorded as fully assessed in their patient record. • 3 Patients' treatment was not regularly reviewed. We found examples of patients who had not been appropriately reviewed or monitored, but the prescribing of medicines had continued. In addition, 5 patients with diabetic retinopathy and an ongoing high blood glucose level did not consistently have evidence of appropriate follow up or review in their patient record. • 2 We found 10 patients with a potential missed diagnosis of chronic kidney disease. We reviewed a random sample of 5 patient records and found that none of these patients had an appropriate code on their patient record, this meant there was a potential risk of them not having a regular review or monitoring. This included one patient who had an existing condition that put them at greater risk. • Referrals were not always appropriately managed. We saw an example of a 2 week wait referral for potential cancer that had not been sent through the referral system. When this was highlighted to the practice, they took action to resolve the issue, however, they did not use learning from this to improve the system. At the time of the inspection, we saw that a process was in place to record and follow up patients to ensure they had been offered an appointment, however, this was not operating effectively. The process of review involved recording when correspondence had been received from the clinic the patient had been referred to, however, there were gaps in records relating to this. We saw there were gaps in recording outcomes for some of these patients where they had not been appropriately followed up to ensure they had attended an appointment. • We found that clinical staff had an understanding of their most clinically vulnerable patients, however, records did not demonstrate that appropriately regular reviews had been consistently held. 	

Effective care for the practice population

Findings

- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. However, feedback from staff included that there were sometimes delays in patients receiving treatment due to the workload of the GP.
- 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. There was a mental health counsellor based at the practice.
- Patients with poor mental health, including dementia, were referred to appropriate services. The practice was a member of the Dementia Action Alliance.

Management of people with long term conditions

Findings

The clinical review of patient records identified that patients' ongoing needs are not always fully assessed. For example, the clinical search identified 13 patients with poorly controlled diabetes and evidence of diabetic retinopathy (eye complications that could lead to sight loss if not treated). From these we reviewed 5 patient records where patients were not always reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm.

The clinical examination of patient records identified that patients were not always appropriately followed up. Our search of patients with hypothyroidism found 3 patients out of 18 who had not had thyroid stimulating hormone testing (to check for appropriate thyroid hormone levels) for more than 18 months which was not in line with guidance of annual monitoring. This included one patient who had a blood result in 2019 that indicated they were likely undertreated.

The clinical review of patients with long term conditions identified deficiencies in the process of review. Our clinical searches identified 14 patients prescribed 2 or more courses of rescue steroids for the treatment of acute asthma exacerbation in the last 12 months. There was a lack of adequate assessment recorded at the time of prescribing and all cases showed examples of a lack of follow up within a week to check their response to treatment. This was not in line with National Institute for Health and Care Excellence (NICE) guidance that patients should be followed up within 48 hours.

The clinical review of patient records identified that patients' ongoing long term condition needs were not fully assessed. For example, we reviewed the records of 10 patients with blood tests indicating they may have an undiagnosed long-term condition of chronic kidney disease which had not been identified or recorded in their records. We reviewed the records of 5 of these patients and found they had not been informed of the diagnosis and there was potential for them not to be reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm.

Examples of other findings include:

- Patients with long-term conditions were offered an annual review to check their health and medicines needs were being met, however this was not always effective. There were systems in place for the GP to work with other health and care professionals to deliver a coordinated package of care to patients with the most complex needs. However, patient records showed that communication was not always effective and appointments with other health and care professionals were not always followed up by the practice to identify outcomes and treatments changes for patients.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma, however this was not in line with recommended timelines.
- 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 influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	17	17	100.0%	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)	17	22	77.3%	Below 80% uptake
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)	17	22	77.3%	Below 80% uptake
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)	16	22	72.7%	Below 80% uptake
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)	17	21	81.0%	Below 90% minimum

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

Any additional evidence or comments

The practice achievement for childhood immunisations showed they were below the 80% uptake for immunisations for children aged 2 and below the 90% minimum for immunisations of children aged 5. The

practice nurse had a system for following up childhood immunisations and this was supported by administrative staff. The practice was aware of uptake levels and staff told us they had a few families that had consistently declined immunisation. They had processes in place for regular follow up and sharing of information so that informed decisions could be made.

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)	43.4%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	59.9%	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). (31/12/2022 to 31/12/2022) (UKHSA)	67.7%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	20.0%	54.4%	54.9%	No statistical variation

Any additional evidence or comments

The practice achievement for cervical screening was below the 70% uptake rate. The nurse carried out cervical screening and had a system for follow up where patients did not respond to screening requests. There were additional appointments available through the local extended access service. We were told that the nurse had historically held information sessions for the local population that included information about smears in an attempt to improve uptake.

Monitoring care and treatment

The practice had participated in quality improvement activity and reviewed the effectiveness and appropriateness of the care provided in some areas. However, there was not a comprehensive programme of quality improvement and we saw limited evidence of monitoring of the outcomes of care and treatment in some areas of risk.

	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.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:

- A 2022 clinical audit of dependency forming medicines resulted in a 20% reduction in opiate prescribing.
- The practice had undertaken some medicines audits relating to patients prescribed valproate (for the treatment of epilepsy) in patients of childbearing age where there was a potential risk of congenital abnormalities. The audit identified that 2 out of 3 patients of child bearing potential did not have a record of an annual assessment and risk acknowledgement form completed. The outcome of the audit indicated that the assessment and acknowledgement form had been completed. However, the audit did not include a date and there was no indication if a repeat audit was to be carried out.
- The practice had undertaken an audit of oral anticoagulants (treatment where there is a risk of blood clots) in April 2023 to ensure patients were safely monitored. Results of the audit showed that 1 out of 44 patients required a dose change which was carried out.

Any additional evidence or comments

Through our clinical searches we identified areas where quality improvements needed to be made. For example, in relation to medicines that require monitoring, actions relating to safety alerts and long term condition monitoring and review.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	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.	n/a
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:	
We saw evidence of clinical staff training to ensure they had the skills and knowledge to deliver effective care, support and treatment. However, staff did not all have a record of mandatory training completion in areas of relevance. This included sepsis awareness, fire safety, practical basic life support training and assessment for clinical staff (in line with Resuscitation Council UK guidance) and infection control training for GPs.	
Most staff had a record of a completed induction when commencing in post. However, records relating to a locum GP and a volunteer did not include evidence of a completed induction. In addition, we saw an induction	

record for one member of the clinical team that included a record of a review that was due to be undertaken at the end of the first 4 weeks after commencing in post, however, this was signed as complete on the first day of their induction.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment, however, patient records did not always include up to date evidence of this and communication around follow up with specialist services was inconsistent.

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Our review of patient records found that evidence of follow up when patients had been referred to specialist services was inconsistent. For example, we reviewed the records of patients who had been referred to the local diabetic specialist team and found there had been no follow up by the practice 4 months after the referral.</p>	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice hosted diabetes education and awareness training for the local community. In addition, the service hosted yoga and complementary therapies within the practice for patients with mobility or chronic pain issues.</p>	

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. 1	Y
Explanation of any answers and additional evidence: Decisions about DNACPR were discussed with patients and those close to them. We reviewed one DNACPR decision with the lead GP and found that consideration had been made for the patient’s wishes and preferences.	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Patient feedback	
Source	Feedback
Feedback from patients	Staff are helpful and professional. They are hard working.

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 stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	91.9%	87.5%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	92.7%	86.7%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	94.6%	94.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	82.3%	77.9%	72.4%	No statistical variation

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

Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	Staff are kind and compassionate. They are always willing to provide support. The GP is very caring.

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 stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	97.3%	91.9%	89.9%	No statistical variation
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	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 121 carers which was 5% of the practice population.
How the practice supported carers (including young carers).	Carers were supported through health checks, immunisations and signposting to other support services. They had access to social prescribers and health coaches as needed. A member of the administrative team was the carer's advocate. A register was maintained and information sent out.
How the practice supported recently bereaved patients.	Recently bereaved patients received a phone call from the practice to identify any support needs.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial

The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Practice staff had a good understanding of the needs of the local community. Services were integrated and we heard of examples where practice staff worked closely with local community groups to ensure patients had the appropriate levels of support. There was clear recognition of the high levels of deprivation and additional support needs that some patients had. Services had been developed within the practice to support the social, emotional and psychological needs of patients as well as the physical. Examples included the hosting of yoga and complementary therapies as well as a mental health counsellor. We heard about examples of practice staff giving talks within the local community to provide education for patients, for example, in relation to cervical screening and childhood immunisations.</p> <p>As part of the primary care network services, there was a hub available where pharmacy support, social prescribing and care coordinators worked centrally to provide additional support to the practice population. Staff told us this was helpful for patients with additional needs and those who attended the practice frequently and may be in need of more social intervention and support. This included care coordinators accompanying patients to appointments when the need was identified in order to remove some of the practical barriers preventing patients from attending.</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
Appointments available:	
Monday	9am – 1pm and 3pm – 6pm
Tuesday	9am – 1pm and 3pm – 6pm
Wednesday	9am – 1pm and 3pm – 6pm
Thursday	9am – 1pm and 3pm – 6pm

Friday

9am – 1pm and 3pm – 6pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday 9am until 1pm. Remote consultations were also available through the GP federation, where patients were also offered a telephone appointment and face to face appointments when required.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. However, we were told that most patients who were homeless were supported to register with a local dedicated GP practice.
- The practice was a member of Dementia Action and had pledged to ensure that patients with Dementia were contacted shortly before their appointments to ensure attendance.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence: Patients could make appointments by telephone, in person or online via the practice website. The practice managed the number of appointments to ensure that all patients who rang on the day could be seen on the day, if required. This included offering appointments from the local extended access service. Patients were	

triaged by the GP and telephoned first in case the problem could be dealt with over the phone. A certain number of appointments were secured for patients with urgent needs.

On the day of our inspection we found patients could get an appointment on the same day or within 2 weeks for a non-urgent pre booked appointment.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	66.7%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	61.0%	61.7%	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)	61.2%	61.2%	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)	76.0%	76.7%	71.9%	No statistical variation

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

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

	Y/N/Partial
Information about how to complain was readily available.	Y

There was evidence that complaints were used to drive continuous improvement.	N
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Examples of learning from complaints.

Complaint	Specific action taken
A 2 week wait referral for potential cancer was delayed.	Action taken to resolve the issue for the patient and ensure the referral was received and acted on, so that the patient was offered an appointment. No review of the referral system or investigation into why the delay occurred was carried out. No evidence of learning from the incident to reduce the risk of reoccurrence. Discussion was held with the GP and administrator involved but no evidence of wider discussion with the staff team or identification and sharing of learning. No evidence of formal response or reference to the ombudsman should the complainant not be satisfied with the response.
A delay in issuing a death certificate.	The death certificate was issued within a few days of the complaint. However, there was no record of a cause for the delay, or an apology to the complainant. There was no formal response recorded and no evidence of reference to the ombudsman as detailed in the complaints policy.

Well-led

Rating: Requires Improvement

We rated the practice as requires improvement for providing well-led services. This is because:

- The delivery of high-quality care was not assured by the leadership, governance or culture in place.
- We were not assured that comprehensive and effective systems were in place and regularly reviewed to identify and manage risk.
- Governance arrangements and their purpose were not always clear. There were limited processes to review the governance framework. The systems for assessing, monitoring and improving the quality and safety of the service were not always effective.
- There was limited understanding of the management of risks and issues. Leaders lacked oversight of some processes and therefore failed to identify risks when those processes did not operate as intended.
- The practice could not demonstrate that they used data and information proactively to drive and support decision making.
- There was limited evidence of systems and processes for learning and continuous improvement.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
<p>Explanation of any answers and additional evidence:</p> <p>Leaders demonstrated they understood some of the challenges to quality and sustainability. They understood issues in relation to staffing and capacity within the practice. However, there were no clear plans in place to address this. Practice leads acknowledged an understanding of the need for succession planning in relation to clinical staff within the practice. There was one principal GP and one practice nurse. However, there was no succession plan in place.</p> <p>There were gaps in assurance processes that had not been identified by leaders and it was not clear that leaders had the capacity to address them. We found that there was a lack of oversight in key areas including; the safety systems in place, medicines management, risk management, referral systems and governance arrangements. All of which had the ability to compromise the quality of care provided by the practice.</p> <p>The majority of staff reported that leaders were supportive and approachable and described a kind and caring approach to the leadership of the practice.</p>	

Vision and strategy

The practice had a clear vision to provide high quality sustainable care, but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice vision included priorities such as collaboration with the local community and other local services. They had a clear patient focus and viewed healthcare holistically, with complementary therapies and exercise sessions hosted within the practice. There was a focus on providing a good customer experience and staff understood their role in this.</p> <p>The practice did not have a formal strategy and there was a lack of management planning in some areas, including in relation to patient safety and sustainability.</p>	

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	N
<p>Explanation of any answers and additional evidence:</p> <p>Most staff told us they felt supported by the leaders within the service. We were told that staff were largely supported to carry out their roles and that they felt their efforts were suitably recognised. Specific examples included recognition of events such as staff birthdays.</p> <p>Leaders were aware of the requirements relating to duty of candour, however, we did not see evidence of this when we reviewed complaints and significant events. For example, records did not include evidence of apologies and the practice were unable to provide a significant event or duty of candour policy at the time of the inspection.</p> <p>We viewed an up to date whistleblowing policy and found that details of integrated care board (ICB) local freedom to speak up guardians were included. Most staff told us they felt able to raise concerns without fear of retribution. However, we also found that some staff felt that communication within the practice could improve and be more open. For example, in relation to being given conflicting information from different leads within the practice.</p> <p>There was no evidence that staff had undertaken equality and diversity training. However, staff were able to describe how they supported patients without discrimination.</p>	

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

Source	Feedback
Staff questionnaire feedback	<ul style="list-style-type: none"> • There is great interaction among the staff and everybody is willing to help and go the extra mile • I feel like there is not always great communication between management. • I love working here. We have a great working relationship. • I don't know any other employer who goes to the lengths that this surgery does to look after their staff. • Views are not always listened to.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Partial
Explanation of any answers and additional evidence: Governance systems and processes were not established and operating effectively. In particular, we had concerns about referral processes, high-risk medicines and medicines that required additional monitoring, action relating to safety alerts, medicines management, long term condition monitoring and assessment processes, safety and risk management processes for the premises, significant events, complaints, recruitment checks, and staff training. We found that where governance arrangements were not established or implemented effectively this was due to the lack of capacity and understanding of leaders. Policies and procedures were not all documented, clearly accessible, reviewed or up to date. The practice did not provide us with a significant event or duty of candour policy and there was more than one version of the practice complaints policy held in the policy folder. We saw evidence that the practice was not following its own policies. For example, the practice had a health and safety policy which clearly stated the responsibilities within the practice and those of the landlord. A fire safety policy clearly stated the responsibility of the practice to ensure a fire safety log book of relevant checks was maintained, however, the practice manager was unable to provide this during the inspection. A complaints policy included that a final formal response should be made following investigation but there was no evidence of written records of this. In addition, there was no record that complainants had been given information on how to raise concerns with the ombudsman if they were not satisfied with the practice approach to their complaint. There were no records that this aspect of the policy had been followed. Governance with third parties were not always effective. For example, the practice were unable to provide oversight or assurance that actions from risk assessments and health and safety processes had been completed by the landlord of the premises.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We were not assured that comprehensive assurance systems and processes were in place, and regularly reviewed to manage risk and some performance data. For example, we found leaders had not consistently undertaken regular checks to ensure patients' health was always monitored in relation to the use of some medicines. Therefore, they could not demonstrate they proactively identified and responded to all risks and assessed the impact on safety and quality.</p> <p>The systems for identifying, managing and mitigating risks were not always clear or effective. Leaders lacked oversight of some processes and therefore failed to identify risks when those processes did not operate as intended. This included; medicines management, the management of safety alerts, health and safety, the management of significant events and complaints, referral processes, staff training and recruitment.</p> <p>There was no systematic programme of clinical and internal audit; therefore, quality improvement was limited and did not include some areas where the need for improvement had been identified during our inspection.</p>	

Appropriate and accurate information

The practice could not demonstrate a commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us they monitored patient outcomes, but clinical records relating to this showed gaps in monitoring and record keeping. There were areas of prescribing that were significantly higher than local and national averages; including the prescribing of antibiotics and gabapentin. The uptake of child immunisations and of cervical screening was below target. The practice was aware of these but did not describe any specific actions they were carrying out to improve performance. Meetings between management staff and clinical staff were largely undocumented. This meant the practice could not demonstrate that they used performance information to hold staff and management to account.</p>	

Governance and oversight of remote services

	Y/N/Partial
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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, however, this was not always consistent.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Not all staff felt their views were always reflected in the planning and delivery of services. Full staff and clinical meetings were not regularly held within the practice, with most discussions being held informally due to the size of the practice. This meant there was limited evidence of engagement with staff about practice issues.</p> <p>The practice worked closely with the local federation and primary care network and we saw evidence of attendance from practice representatives at meetings to discuss areas such as extended access and local community work. However, there was a lack of evidence of engagement with the local integrated care board (ICB).</p>	

Feedback from Patient Participation Group.

Feedback

Feedback from the patient participation group (PPG) included that the practice was responsive to suggestions and engaged regularly with the group, including organising meetings to review relevant issues.

Any additional evidence

We were told that the PPG had members that were active and the practice manager consulted with them on specific issues. Engagement included meetings which had been irregular during the pandemic but had recommenced in recent months.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement

The practice were unable to demonstrate a consistent focus on continuous learning and improvement. For example, significant events and complaints were not always investigated to identify the root cause of the problem. There was no evidence of discussions about learning and improvements within the practice and meetings were not regularly held where these discussions may be held.

There were a number of areas identified during the inspection where improvements were required. However, there was some evidence of actions to improve in relation to de-prescribing of dependency forming medicines and action to improve monitoring of patients prescribed oral anticoagulants.

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

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.