

Inspection Evidence Table

Bucklands End Lane Surgery

(1-582422849)

Inspection Date: 19 September 2023

Date of data download: 25/08/2023

Overall rating: Requires improvement

The practice is rated requires improvement overall. The provider had developed safety and governance systems to ensure services were delivered safely. However, not all systems, for example, infection prevention and control and the management of prescription stationery were fully effective. The provider had taken action to improve access, however, could not fully demonstrate that changes had led to improved patient satisfaction. Therefore, this practice is now rated requires improvement.

Context

The practice is situated within the Birmingham and Solihull (BSOL) Integrated Care Board (ICB) and provides General Medical Services (GMS) to a patient population of about 6,200. This is part of a contract held with NHS England.

The practice is part of a wider network of GP practices called Birmingham East Central Primary care network (PCN).

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the second lowest decile (two of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 29% Asian, 59% White, 7% Black, 4% Mixed, and 1% Other.

The age distribution of the practice population mirrored the local and national averages. There are equal numbers of male patients registered at the practice compared to females.

Specific challenges the practice was experiencing at the time of inspection:

Due to the expansion of services and because they were a teaching practice, the provider had identified they needed more clinical rooms than the 8 they currently had. The provider had purchased the building next door with the intention of extending beyond the 8 clinical rooms available. However, at the time of the inspection, planning consent from the local council had not been granted to convert the building into suitable premises,

that could be used as additional clinical rooms. This was impacting on the provider’s ability to employ more clinical staff, for example, another practice nurse, or deliver social prescribing sessions from this practice.

The provider monitored patient satisfaction through various methods and was aware that patient satisfaction with telephone and appointment access was poor. They told us of actions they had already taken following previous national patient surveys to improve access and of their plans to change telephone provider within the next 12 months.

Safe

Rating: Requires improvement

The provider had developed safety systems to ensure services were delivered safely, and patients were safeguarded from harm. We found most systems were well embedded, however, processes to manage infection prevention and control, prescription stationery and calibration of medical equipment required improvement. Therefore, the practice is now rated requires improvement for providing safe services.

Safety systems and processes

The practice have 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. | Yes |
| Partners and staff were trained to appropriate levels for their role. | Yes |
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| The Out of Hours service was informed of relevant safeguarding information. | Yes |
| There were systems to identify vulnerable patients on record. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| 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. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had safeguarding leads. The leads held registers of patients who were considered vulnerable. We found that registers were reviewed and up to date. • We viewed meeting minutes that showed relevant practice staff met regularly to discuss vulnerable patients, however, these meetings did not include external services such as health visitors. Staff told us | |

they communicated with health visitors as needed and during the inspection we discussed examples where staff had contacted health visitors and social services to safeguard and support patients.

- We found all staff had received appropriate safeguarding training and all staff we spoke with told us how they would identify safeguarding concerns and who they would contact for advice. However, policies we viewed did not reflect updated training requirements.
- Staff had access to contact numbers for external safeguarding teams and the practice placed alerts on patients' record to alert staff that there were safeguarding concerns for patients or members of their household.
- DBS checks were carried out for staff where required. A DBS check identifies whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- We saw where DBS checks were awaited, the practice had carried out a risk assessment to monitor and mitigate risk, and staff completed a self-declaration form.

| Recruitment systems | Y/N/Partial |
|--|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role. | Partial |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had recruitment processes in place to ensure relevant information was collected at the time of recruitment and on an ongoing basis. • We viewed 2 staff files and we found there was partial information relating to staff vaccination for a clinical staff member. This was provided immediately following the inspection. Staff vaccination information for the non-clinical staff member's file we viewed had been requested before the inspection and was awaited. • The practice had assessed all staff immunity for Hepatitis B and we saw that 6 staff were awaiting boosters. • The provider sent us evidence, that showed, following the inspection, they had risk assessed staff roles while staff awaited the booster, to monitor and mitigate risk. • The provider sent further evidence that showed, following the inspection all staff that required it, had received a Hepatitis B booster vaccination. Where staff had refused the vaccination, the provider had asked staff to sign a disclaimer that was held in their personnel file. | |

| 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: | July 2023 |
| There was a fire procedure. | Yes |
| Date of fire risk assessment: | February 2023 |
| Actions from fire risk assessment were identified and completed. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The health and safety risk assessment we viewed did not include information to indicate when it had been completed, who had completed it and when it needed to be reviewed. We found that actions resulting from the risk assessment had been completed or there were dates for completion. • The health and safety risk assessment included most major health and safety risks, however, it was not comprehensive and did not consider all possible health and safety risks or hazards for staff or patients. The provider sent us evidence to show, following the inspection they had taken action to review and improve their assessment of health and safety. • During the inspection, we identified that a light in one of the clinical rooms was not working, this had not been previously identified or reported by staff. The practice management team told us, they did not carry out regular walk arounds the building to identify health and safety issues, however, staff were expected to report issues when they arose. Following the inspection, the provider sent us evidence to show that processes were in place for staff to identify and report any faults or maintenance issues. • The practice had completed a premises security risk assessment and we saw evidence of a risk assessments to assess the safety of window blinds. • Staff told us a legionella risk assessment had been completed just before the inspection by an external company and the report was awaited. Staff told us that water samples had been taken and staff were verbally informed that there were no actions. • The practice had systems in place to test electrical equipment (PAT testing) to ensure it was safe to use. We found some medical equipment had been calibrated, for example the spirometer and ECG machine, however the provider could not demonstrate that all medical equipment had been calibrated in line with manufacturer's instructions. The provider sent us evidence to show, following the inspection, calibration of medical vaccine fridges and weighing scales had been carried out in October 2023. • The practice had systems in place to monitor and check that fire-fighting equipment and alarms were tested regularly. • We saw evidence of a control of substances hazardous to health (COSHH) risk assessment and safety sheets were available for staff. • We saw evidence of electrical safety certificates and safety information relating to the installation of the gas boiler. | |

Infection prevention and control

There were gaps in processes to monitor and manage infection prevention and control.

| | Y/N/Partial |
|--|-------------|
| Staff had received effective training on infection prevention and control. | Yes |
| Infection prevention and control audits were carried out. | Yes |
| Date of last infection prevention and control audit: | 3 July 2023 |
| 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. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had designated leads for infection prevention and control (IPC).• The IPC leads had carried out an IPC audit in July 2023.• We saw the practice had an action plan to monitor that actions from the IPC audit had been carried out. However, we found not all actions had been added to the action plan or actions had no completion date.• For example, there was no completion date for the cleaner to complete IPC training. It had been identified on the audit that painting was needed, however this had not been added to the action plan. We also saw on the audit that it had been identified that carpet needed replacing with suitable flooring, however, this had not been added to the action plan. The management team told us the plan was to decorate and replace flooring when the building next door was renovated, however, there was no date for completion.• The practice employed a cleaner and we saw evidence of cleaning schedules in place. Clinical staff had their own cleaning schedules for their clinical areas and equipment.• There were carpets in the patient entrance and in non-clinical areas. Staff told us the cleaner vacuumed carpets each time they were on site. However, there were no records or schedule for deep cleaning. The provider informed us the entire building had a deep clean during the COVID-19 pandemic. The management team told us, following the inspection, they arranged for deep cleaning of the carpets to be carried out and they would be deep cleaned 6 monthly in the future. The provider sent us evidence to show, following the inspection, they had reviewed and updated their IPC action plan and deep carpet cleaning had been carried out in September 2023.• The IPC audit had also identified that cleaning equipment such as mops and buckets were stored appropriately. However, during the inspection we found the cleaners cupboard was untidy, cluttered and mops were not stored appropriately.• The provider took immediate action, following the inspection to improve the cleaner's cupboard and ensure equipment was stored more appropriately to improve IPC. | |

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. | Yes |
| There was an effective induction system for temporary staff tailored to their role. | Yes |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Yes |
| 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. | Yes |
| There were enough staff to provide appointments and prevent staff from working excessive hours. | Yes |
| Explanation of any answers and additional evidence: | |

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. | Yes |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Yes |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Yes |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.• The provider had implemented processes to ensure blood test results and external correspondence was actioned in a timely manner. | |

Appropriate and safe use of medicines

The practice 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) (01/07/2022 to 30/06/2023) (NHSBSA) | 0.88 | 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). (01/07/2022 to 30/06/2023) (NHSBSA) | 5.7% | 7.1% | 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 (01/01/2023 to 30/06/2023) (NHSBSA) | 5.09 | 5.18 | 5.24 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA) | 124.7‰ | 116.2‰ | 129.5‰ | 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) | 0.60 | 0.58 | 0.55 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA) | 7.6‰ | 7.9‰ | 6.8‰ | No statistical variation |

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

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Partial |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| 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. | Yes |
| There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. 1 | Yes |

| | |
|---|-----|
| 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. | Yes |
| 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. 2 | Yes |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. | Yes |
| 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. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| 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. | Yes |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective. | Yes |
| <p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> • Our clinical searches and record reviews indicated that patients on high risk medicines received required monitoring and follow up in line with guidelines. • We found that blank prescription stationery was stored securely however, the system to monitor its use was not effective. The practice sent us evidence to show, following the inspection they had immediately reviewed and improved their processes. | |

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. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |

| | |
|---|---|
| Number of events recorded in last 12 months: | 8 |
| Number of events that required action: | 8 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • Staff we spoke with were able to share examples of incidents or significant events they had either reported or learnt from. • We saw from meeting minutes that significant events and incidents were discussed with staff, this included learning and actions for staff. • The provider monitored all incidents and looked for trends, so that appropriate action could be taken to prevent incidents from occurring again. | |

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

| Event | Specific action taken |
|---|--|
| Patient registration issue. | <ul style="list-style-type: none"> • Staff reported the incident to the practice management team. • The practice management team sought external support, informed the patient and provided necessary support. • The practice management team shared the incident with all staff and provided training for relevant staff. |
| Patient admitted to hospital with sepsis. | <ul style="list-style-type: none"> • Staff reported the incident. • The events leading up to the incident were discussed with relevant staff in a clinical meeting. • It was discussed that staff had provided appropriate care and advice. • The provider reviewed the current arrangements in place to help staff identify and manage sepsis. • Staff received training on relevant medical conditions including refresher training on how to identify and manage sepsis. |

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | Yes |
| Staff understood how to deal with alerts. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • Our record reviews and clinical searches indicated the practice had effective systems in place to receive and act on safety alerts. • We saw examples of actions taken on recent alerts. • From meeting minutes we viewed we saw that information was shared with relevant staff. | |

Effective

Rating: Good

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

Effective needs assessment, care and treatment

Patients' needs were 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. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Yes |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic. | Yes |
| The practice prioritised care for their most clinically vulnerable patients. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none">• Our clinical searches and record reviews indicated that patients' were monitored and reviewed in line with guidelines. Records we viewed were completed to a good standard and indicated that needs were fully assessed.• From records we viewed we saw that patients received effective medicine reviews. | |

Effective care for the practice population

Findings

- Our clinical searches and record reviews indicated that patients 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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. Staff told us substance misuse clinics were held at the practice. These were run by the local substance misuse service. One of the GP partners worked closely with the service and reviewed patients every 3 months.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice provided contraception advice and treatment at the practice, this included the insertion of long acting reversible contraception (coils).

Management of people with long term conditions

Findings

- Our clinical searches and record reviews indicated that for patients with long term conditions, their ongoing long term condition needs were fully assessed and monitored in line with guidelines.
- The provider had implemented systems to monitor patients for potential missed diagnosis of diabetes and chronic kidney disease.
- Patients with asthma exacerbation requiring high dose steroid treatment for severe asthma episodes were always followed up in line with national guidance to ensure they received appropriate care.

- Patients with long term conditions were reviewed to ensure their treatment was optimised in line with national guidance.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice identified diabetic patients that needed additional support to reduce their risk of complications. Those patients were discussed at meetings with a diabetes consultant to provide an expert guided care plan. The practice also invited patients with uncontrolled diabetes to attend local diabetes health promotion and support programmes.
- The practice identified and referred patients with complex respiratory needs to a specialist respiratory clinic.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

| Child Immunisation | Numerator | Denominator | Practice | Comparison to WHO target of 95% |
|---|-----------|-------------|----------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus 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) | 52 | 65 | 80.0% | Below 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 62 | 82 | 75.6% | 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) | 62 | 82 | 75.6% | 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) | 63 | 82 | 76.8% | 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) | 61 | 80 | 76.3% | Below 80% uptake |
|--|----|----|-------|------------------|

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 provider told us they were aware that their uptake of children’s immunisations was below the World Health Organisation (WHO) targets. They explained that attendance for children’s immunisations fell significantly during the COVID-19 pandemic, despite the practice remaining open for immunisations.
- Published data showed that the practice was consistently meeting the 95% WHO uptake target before the COVID-19 pandemic for 4 out of 5 indicators.
- The provider told us uptake was improving. The practice management team monitored uptake of vaccinations and worked with the Child Health Information Services (CHIS) to obtain current data and then contacted parents/carers of children that required vaccinations.
- To increase uptake, the practice offered appointments for a 6-week baby check with the GP at the same time as the babies first immunisations.
- Staff followed up any patients that did not attend. Staff told us, most children had the vaccinations even if they fell outside of the required timescale.
- The GP met with parents who refused vaccinations, to provide advice and guidance. Staff told us, some parents changed their mind and agreed to vaccinations after speaking with the GP. If parents/carers still refused to vaccinate their child, after speaking with the GP, they were asked to sign a disclaimer that was added to the patient’s record.

| 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) | 12.8% | 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) | 60.3% | 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). (3/31/2023 to 3/31/2023) (UKHSA) | 65.2% | 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) (4/1/2021 to 3/31/2022) (UKHSA) | 47.4% | 53.2% | 54.9% | No statistical variation |
|--|-------|-------|-------|--------------------------|

Any additional evidence or comments

- The provider had implemented systems to monitor uptake and contact patients if they did not attend for cancer screening.
- The provider was aware they were below target for breast screening in 2021/2022. They explained this may have been due to patients not attending for screening during the COVID-19 pandemic. The practice management team had contacted the breast screening department for the latest available data for April 2022 to May 2022. The unverified data showed that 63% of all eligible patients had attended for breast screening between April and May 2022. Staff told us the breast screening department sent the practice a list of patients who did not attend for their appointment. The practice then contacted patients to encourage them to attend.
- Staff told us they promoted breast screening in the practice, including with the use of posters, when they were made aware the screening unit would next be in the area.
- Staff told us the screening unit was located in an accessible car park that was easy for patients to get to.
- The provider was aware that uptake with cervical cancer screening was below target and told us they struggled in particular with the younger age group (25 to 49 year). Staff monitored uptake and contacted patients who did not attend appointments. Staff placed alerts on patient records to alert staff and offer screening opportunistically.
- The practice offered appointments for cervical screening through the week and patients could request appointments through the new practice website the provider had implemented in 2022 to improve appointment access.
- Published data showed that attendance for cervical screening had fallen from 68% in March 2020 and had remained at approximately 65% since.
- The practice had systems to monitor that a result had been received for every sample and that patients who needed further investigation had been referred and then attended their appointments.

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. | Yes |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | Yes |

| | |
|--|-----|
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Yes |
| <ul style="list-style-type: none"> The provider told us their audit program was designed in response to issues they found in clinical care or where they needed greater analysis on how they managed patients going forwards to improve care. The provider shared examples of improvements demonstrated through clinical audits. For example, The practice had carried out an audit looking at the monitoring of patients on medicines to help manage their mental health. They audited to check patients had received the required monitoring (physical health checks and blood tests) in line with guidelines. The initial audit in March 2022 included 62 patients and showed 45% of patients included in the audit had some monitoring checks completed but not all. The practice wrote to all patients that required monitoring detailing all the checks they needed. They also placed alerts on patient's records to remind staff. The audit was discussed with clinical staff to discuss actions that were needed to improve care. The practice re-audited this same group of 62 patients in September 2022 and found 87% of these patients had all the required monitoring checks completed. After the audit, the practice contacted the remaining 8 patients (13%) to remind them to attend for monitoring and were able to complete monitoring for a further 3 patients. The practice had carried out an audit in July 2023 of the care and treatment provided to patients with fibromyalgia (a long-term condition that causes pain all over the body). The audit included the review of 14 patients' records. The audit showed that most patients were managed in line with guidelines. Out of the patients included in the audit 9 (64%) were managed without medicine. For example, with exercise and/or psychotherapy. When patients were treated with medicines, this was following discussion with a clinician and a shared management plan in place. The audit showed in 75% of patients, symptoms were controlled through current treatment. | |

| Any additional evidence or comments | |
|---|--|
| <ul style="list-style-type: none"> The practice monitored and discussed performance data to improve care and patient outcomes. The practice carried out non-clinical audits to monitor cleaning standards and patient feedback surveys to monitor patient satisfaction. | |

Effective staffing

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

| | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. | Yes |
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | Yes |
| There was an induction programme for new staff. | Yes |

| | |
|--|-----|
| 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. | Yes |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Yes |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw evidence of clinical supervision in place for non-medical prescribers. The practice was a training practice for medical students and trainee GPs. There was an allocated lead to supervise students and trainees. Feedback we viewed from medical students was positive about the training, support and supervision they had received from the practice. The provider had implemented processes to monitor that staff had completed all necessary training, this included required training and training relevant for individual clinician's specific roles. | |

Coordinating care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Yes |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a designated lead for coordinating care for palliative patients. The practice liaised with community care teams including palliative care nurses as required. The practice identified and referred patients to specialist diabetes and respiratory as required. To improve communication with external services, staff told us healthcare professionals including the palliative care team could contact the practice on a direct line. Practice staff were also able to see information placed on the patient's record by community teams, as they used the same clinical record system. | |

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. | Yes |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Yes |
| Patients had access to appropriate health assessments and checks. | Yes |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Yes |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Staff referred patients to the social prescriber to support patients lead healthier lives. The social prescriber was employed by the primary care network (PCN). The PCN monitored how many patients the practice referred and the outcomes for each patient.• Staff described two projects they were currently involved in to support patients lead healthier lives:• The Health and Harmony project was supporting female patients aged 25 to 40 years, with depression, who were smokers and had a BMI (body mass index) above 30kg/m². One of the GP partners at the practice was leading on this PCN initiative. At the time of the inspection, the practice had referred 13 patients into this project.• The practice also referred patients to a Diabetes Outreach programme. Patients were provided with diet, weight and welfare management support. The program included diabetes focussed clinics for patients to address uncontrolled blood glucose levels and advise on life style changes. At the time of the inspection, the practice had referred 72 patients into this project.• The practice could also refer patients into other projects ran by the PCN for example, teaching patients how to ride a bicycle and offering a bicycle repair shop. | |

Any additional evidence or comments

The provider told us of their plans to increase the range of services offered by the social prescriber from October 2023 onwards.

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. | Yes |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Yes |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. | Yes |
| Explanation of any answers and additional evidence, Our clinical review of notes where a DNACPR decision had been recorded, indicated where possible the patients views had been sought and respected. We saw that information had been shared with relevant agencies. | |

Caring

Rating: Requires improvement

Published data showed a falling trend in patient satisfaction in relation to patient experience. The provider could not demonstrate what action they planned on taking to improve patient satisfaction in this area. Therefore, the practice is now rated requires improvement for providing caring services.

Kindness, respect and compassion

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

| | Y/N/Partial |
|--|-------------|
| Staff understood and respected the personal, cultural, social and religious needs of patients. | Yes |
| Staff displayed understanding and a non-judgemental attitude towards patients. | Yes |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Conversations we heard and observations we made during the inspection between staff and patients, showed staff treating patients with kindness and respect. | |

Patient feedback

| Source | Feedback |
|-------------|--|
| NHS website | <ul style="list-style-type: none"> At the time of the inspection, there were 5 reviews posted on the NHS website between October 2022 and September 2023. Of these reviews, one review related to how staff had treated the patient. The comment was positive about clinical and non-clinical staff. |
| Patients | <ul style="list-style-type: none"> We spoke with 2 patients during the inspection. |

| | |
|--|---|
| | <ul style="list-style-type: none"> Patients told us they were satisfied with the service overall and that staff showed a caring attitude towards them. |
|--|---|

National GP Patient Survey results

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

| Indicator | Practice | SICBL average | England | England comparison |
|---|----------|---------------|---------|--------------------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023) | 65.3% | 81.1% | 85.0% | Variation (negative) |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023) | 71.7% | 79.3% | 83.8% | Tending towards variation (negative) |
| 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 (01/01/2023 to 30/04/2023) | 82.0% | 90.3% | 93.0% | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023) | 47.2% | 65.2% | 71.3% | Tending towards variation (negative) |

Any additional evidence or comments

- The practice management team had met to discuss the 2023 national patient survey results and review the actions they had taken previously to improve patient satisfaction. We saw they had formed an initial plan of which areas they needed to focus on and discuss with the wider team. At the time of the inspection, they had not yet met with the wider team and could not demonstrate to us what specific action they planned to take to improve patient satisfaction in the above areas.
- Previous actions the provider had taken to improve patient satisfaction included reviewing the length of appointment times to ensure patients had sufficient time to ask questions and for staff to collect relevant information.
- Staff told us, through patient feedback they received, factors outside of their control, for example patient expectations about services that were no longer provided on the NHS or referrals to secondary care and long waiting times, impacted on overall patient satisfaction with the practice.
- Staff also felt that because telephone access was difficult, this may also be affecting overall experience for patients.

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

Any additional evidence

The practice had completed their own in-house patient survey in July 2023. The provider sent us evidence that showed 75 patients who had attended the practice for an appointment in July 2023 had completed the survey and initial analysis showed that results were positive:

- 49% of patients completing the survey were very satisfied with the care they had received.
- 42% were satisfied with the care they had received
- 5% were neither satisfied nor dissatisfied.
- 4% were dissatisfied with the care they had received.
- 86% of patients completing the survey said they would recommend the practice.

At the time of the inspection, the practice management team had met to discuss the results. However, all practice staff had not yet met to discuss the results and form an action plan.

The provider monitored responses to the Friends and Family test. Patients were sent a link to the survey through text message. Data we viewed showed:

- In June 2023 the practice received 75 responses. Of those responding, 76% thought the practice was very good, 17% thought it was good, 3% replied it was neither good nor bad, and 4% responded it was poor.
- In July 2023, the practice received 161 responses. Of those responding, 63% thought the practice was very good, 27% thought it was good, 5% replied it was neither good nor bad, and 6% responded it was poor.
- In August 2023, the practice received 129 responses. Of those responding, 64% thought the practice was very good, 23% thought it was good, 7% replied it was neither good nor bad, and 6% responded it was poor.

When patients left comments about staff, these were shared with relevant staff. During the inspection, staff shared positive feedback with us that had been left by patients.

The provider sent us further information, following the inspection, they told us the practice would conduct a patient survey through an external organisation in June 2024 to review how effective their action plan to improve patient satisfaction had been.

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. | Yes |

| | |
|---|-----|
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |
|---|-----|

National GP Patient Survey results

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

| Indicator | Practice | SICBL average | England | England comparison |
|---|----------|---------------|---------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023) | 80.7% | 87.3% | 90.3% | No statistical variation |
| Any additional evidence or comments | | | | |
| <ul style="list-style-type: none"> The practice management team had met to discuss the results of the survey, however had not yet formed specific actions on how to improve satisfaction. During our record reviews, including care plans we viewed for patients with long term conditions and DNACPR records, we found that patients and/or carers were involved in decisions about their care and treatment. | | | | |
| | | | | Y/N/Partial |
| Interpretation services were available for patients who did not have English as a first language. | | | | Yes |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | | | | Yes |
| Information leaflets were available in other languages and in easy read format. | | | | Yes |
| Information about support groups was available on the practice website. | | | | Yes |
| Explanation of any answers and additional evidence: | | | | |
| <ul style="list-style-type: none"> Staff told us they tried to meet their patients' language and communication needs where possible. At registration, patients were asked about any disabilities, language issues or difficulties with communication, and these were recorded and highlighted on the patient's record. Staff told us this was an essential process when registering their asylum seeker patients who had many language needs. Staff told us they could print out patient information (including in large print and in different languages) or send patients a link to information using text message. If a patient required an interpreter, this was arranged at the time of booking the appointment. Staff told us they worked with the local organisation that was housing asylum seekers to arrange appointments with the appropriate clinician and arrange an interpreter. | | | | |

- Staff told us they did not routinely stock patient information in alternative languages, however, when they supported the Breast Screening programme by supplying their practice's headed paper, they were aware that letters were sent out to patients in different languages.
- The practice had carried out an assessment to check they met the Accessible Information Standard (AIS). The practice organised a British Sign Language translator for appointments. Patients with hearing difficulties could also communicate with the practice using email or the website.
- For patients with a learning disability, staff communicated with carers where appropriate to provide information.
- Staff working at the practice also spoke 5 different languages other than English. This helped to support with patient queries when an interpreter was not available.

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | The practice had identified 32 of their patients as a carer. This was less than 1% of their patient population. |
| How the practice supported carers (including young carers). | <ul style="list-style-type: none"> • The practice offered carers a health check and yearly flu vaccination. • They also sign posted to support services. • We saw there was information for carers in the practice waiting area and on the practice website. |
| How the practice supported recently bereaved patients. | <ul style="list-style-type: none"> • Recently bereaved patients were offered an appointment with the GP. • Patients were signposted to support services. |

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. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff recognised the importance of supporting patients to manage their own health and care when they could and referred them to appropriate support groups or social prescribing projects. • A private area was available for breast feeding, and baby changing facilities were also available. • An accessibility audit had been completed when the building was previously renovated to ensure patients with additional needs could access the building on an equal basis to others. | |

Responsive

Rating: Requires improvement

We recognise the pressure that practices are currently working under and the efforts staff are making to maintain levels of access for their patients. At the same time, our strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. Although we saw the provider was attempting to improve access, this was not yet reflected in the GP patient survey data or other sources of patient feedback.

We also found that published data showed that satisfaction with access had been below local and national averages and on a downward trend since 2021.

Therefore, the rating is requires improvement, as ratings depend on evidence of impact and must reflect the lived experience that people were reporting at the time of inspection.

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. | Yes |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| There were arrangements in place for people who need translation services. | Yes |
| The practice complied with the Accessible Information Standard. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none">• The provider understood their patient population and worked with other local practices within their PCN to tailor services for patients. From evidence we viewed, we saw there was a focus on working with other services to empower patients to lead healthier lives through social prescribing projects and support patients with their general well-being.• The practice was a Veteran Friendly practice, and supported patients who had served in the Armed Forces.• The practice tried to offer appointments with the same clinician where possible for continuity of care. However, recognised this was not always possible. They were a teaching practice and if patients requested appointments on the same day, the request to see a particular clinician could not always be accommodated.• At the time of the inspection, the practice had registered 144 asylum seekers who were being housed in the local area. Initially staff carried out home visits, however over time, this group of patients had started to attend the practice for their appointments. Interpreters were booked in advance of appointments. | |

| Practice Opening Times | |
|---|-------------------|
| Day | Time |
| Monday | 8.30 am – 6.30 pm |
| Tuesday | 8.30 am – 8 pm |
| Wednesday | 8.30 am – 6.30 pm |
| Thursday | 8.30 am – 6.30 pm |
| Friday | 8.30 am – 6.30 pm |
| Saturday | 9 am – 5 pm |
| Appointments available: | |
| Monday | 8.30 am - 5.45 pm |
| Tuesday | 8.30 am – 7.45 pm |
| Wednesday | 8.30 am - 5.45 pm |
| Thursday | 8.30 am - 5.45 pm |
| Friday | 8.30 am - 5.45 pm |
| Saturday | 9 am – 5 pm |
| <p>On Wednesday and Thursday afternoons after 1pm and when the practice was closed the phone lines were transferred to the out of hours provider BADGER.</p> <p>On Wednesday and Thursday 1 pm - 6.30 pm, patients could still attend the practice for pre-booked appointments or to request a face to face appointment, if there was availability, an appointment would be offered.</p> <p>BADGER communicated with the practice the next day to inform them about any queries they had handled.</p> <p>The practice had systems in place to share information with BADGER about any vulnerable patients.</p> <p>BADGER had a direct line for telephone access to the clinicians if they had an urgent query.</p> <p>Saturday appointments were available through arrangements with the PCN.</p> | |

| Further information about how the practice is responding to the needs of their population |
|--|
| <ul style="list-style-type: none"> • 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. |

- There was a medicines delivery service for housebound patients. This was arranged through local pharmacies.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues or those patients that may be vulnerable.
- Additional GP and nurse appointments were available until 8 pm on a Tuesday for patients who could not attend for appointments in normal working hours for example, school age children.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8 pm on a Tuesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a PCN. Appointments were available Saturday 9 am till 5 pm.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. We saw that staff had completed required training and had subsequently reviewed their registers and processes to ensure they were identifying patients that might need more support for example autistic patients and/or patients with ADHD (attention deficit hyperactivity disorder).

Access to the service

Despite action the provider had taken to improve access, patient feedback indicated that people were not always able to access care and treatment in a timely way.

| | Y/N/Partial |
|---|-------------|
| Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice. | Partial |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online). | Yes |
| Patients were able to make appointments in a way which met their needs. | Partial |
| There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded). | Yes |
| Patients with most urgent needs had their care and treatment prioritised. | Yes |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages). | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • The practice monitored Friends and Family data, reviews left on the NHS UK website and complaints to help monitor patient satisfaction information in relation to access. | |

- Published patient survey data and low levels of patient satisfaction about telephone and appointment access indicated that patients were not always able to make appointments in a way which met their needs. The provider told us patients could make an appointment face to face at the surgery, through telephone, email and online. They told us by offering a range of methods this helped all patients to access the practice on an equal basis.
- The provider had met to review and discuss the results of the national patient survey and had reviewed actions taken so far following previous national patient surveys to improve access, however had not yet met with the wider practice for form an action plan to improve access further.
- The provider had employed a new receptionist to increase the number of staff available to answer calls. The clinical pharmacist and physician's associate had also increased their hours to provide more appointments.
- The provider reviewed appointment data and discussed it monthly with the PCN. They provided data that showed between September 2022 and September 2023 the practice had provided 39,078 appointments, 26,825 of these appointments were face to face appointments, 19,091 were with a GP and 19,489 were on the day appointments. The provider told us there were offering 35 more appointments each day when compared with the same time period 12 months ago.
- The provider recognised that satisfaction with telephone access was poor and told us of their plans to change telephone provider within the next 12 months. They told us they were unable to leave their current contract provider any sooner.
- To improve telephone and appointment access the provider had commissioned a new website in August 2022 that allowed patients easier online access to the practice. At the time of the inspection, the practice had processed 2,775 requests that had come into the practice using the online system.
- The provider gave us data that showed the number of patients using the online system had gradually increased, to approximately 300 requests each month.
- The provider monitored the ages of patients using the system. From data we saw that all age groups accessed the system with majority of patients aged 50-59 years.
- The provider monitored the type of requests coming through and if they were able to resolve the request online or by text message or if the patient needed further support..
- The practice was working with the PCN to improve access further. A representative from the PCN told us they monitored and reviewed data relating to the online system. The practice had been using the improved website for 13 months and now the provider and PCN were confident the online system was working well they planned to increase the advertising for it to encourage more patients to use it.
- Non-clinical staff told us the new online system was working well. They had dedicated staff each day to respond to online queries. Non-clinical staff had received training and were aware when they needed to escalate concerns to a clinician.
- The provider told us they would like to employ another practice nurse and offer more services for example social prescriber events from the practice, however at present they could not offer these services due to limitations of clinical rooms. The provider shared with us their plans to renovate the building next door, however this was dependent on the local authority giving permission to do this.

- The provider sent us further information, following the inspection, they told us the practice would conduct a patient survey through an external organisation in June 2024 to review how effective their action plan to improve patient satisfaction had been.
- Following the inspection, the provider told us they monitored telephone call data monthly and sent us data that showed between October 2022 and September 2023 the practice had answered 64% of all incoming calls.
- The provider also told us they aimed to increase the number of registered users for the NHS App by 5%. They were currently educating their patients about online solutions and apps available to know more about their health profile and services available.
- The Practice was engaging and working with local practices on the programme Right Access First Time (RAFT)
- Patients had on-line access to the practice website where they could request appointments, prescriptions, test results and other administration requests.
- Patient's had access to the practice email.
- Patients were signposted to the local Pharmacy and local HUB community services when appropriate.

National GP Patient Survey results

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

| Indicator | Practice | SICBL average | England | England comparison |
|---|----------|---------------|---------|--------------------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023) | 11.5% | N/A | 49.6% | Significant variation (negative) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023) | 32.4% | 46.7% | 54.4% | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023) | 32.5% | 47.4% | 52.8% | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or | 57.1% | 68.3% | 72.0% | No statistical variation |

| | | | | |
|--|--|--|--|--|
| appointments) they were offered (01/01/2023 to 30/04/2023) | | | | |
|--|--|--|--|--|

Any additional evidence or comments

The provider monitored data relating to access and appointments closely and was working with the PCN to try to improve access to the practice and offer a wider range of services that met their patient population’s needs.

At the time of the inspection, the provider had reviewed the results of the national patient survey however, not yet met with the wider practice team to discuss how to improve access further.

| Source | Feedback |
|---------------------------------------|---|
| NHS.uk website (formerly NHS Choices) | At the time of the inspection, there were 5 reviews posted on the NHS UK website between October 2022 and September 2023. All 5 reviews commented on poor telephone and/or appointment access. We saw the practice had responded to 4 out of 5 comments and signposted patients to their new 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. | 9 |
| 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. | Yes |
| There was evidence that complaints were used to drive continuous improvement. | Yes |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| A complaint was received from a patient who was unhappy with the treatment they had received from the practice. | <ul style="list-style-type: none"> • The practice reviewed and investigated the complaint. • The practice liaised with specialist services to look into the patients concerns. • The patient was reviewed by the specialist service. • No further action was needed by the practice. • The practice had provided the correct care and treatment. |

Well-led

Rating: Good

Leadership capacity and capability

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

| | Y/N/Partial |
|--|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none">• The provider was aware that telephone and appointment access were a challenge. They had taken appropriate action to improve access and had plans in place to change the telephone provider and develop the premises to be able to offer more appointments and offer a wider range of services.• In the meantime they worked collaboratively with other organisations to refer patients to specialist clinics and the PCN for social prescribing projects.• The provider had reviewed their skill mix to assess if it met current and future demand. As a result, existing non-clinical staff were given additional training to enable them to carry out additional tasks. The provider had employed an additional receptionist and increased the hours of the clinical pharmacist and physician's associate. | |

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. | Yes |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes |

| | |
|---|-----|
| Progress against delivery of the strategy was monitored. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice's vision was to help the health and wellbeing of patients and to work in partnership with staff, patients and wider organisations. The practice management team told us the vision had been developed in collaboration with staff and it was discussed with staff during their appraisals. The provider reviewed their strategy and business plan during governance meetings. | |

Culture

The practice had a culture which drove high quality sustainable care

| | Y/N/Partial |
|--|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Yes |
| Staff reported that they felt able to raise concerns without fear of retribution. | Yes |
| 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. | Yes |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | Yes |
| The practice encouraged candour, openness and honesty. | Yes |
| The practice had access to a Freedom to Speak Up Guardian. | Yes |
| Staff had undertaken equality and diversity training. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Many of the staff had worked at the practice a long time and the practice had a high retention rate. Clinical staff who had previously completed training at the practice chose to work at the practice again once qualified. All staff we spoke with shared the provider's vision of providing high quality patient centred care. | |

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

| Source | Feedback |
|--|--|
| Staff we spoke with during the inspection. | <ul style="list-style-type: none"> Staff told us they enjoyed working at the practice. Staff felt supported to deal with complex patients. Staff were supported and encouraged to develop professionally. |

| | |
|--|---|
| | <ul style="list-style-type: none"> Clinical staff including non-medical prescribers told us there was always a GP available to speak to for advice and guidance, and they felt well supported by the GPs to carry out their advanced roles safely. |
|--|---|

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. | Yes |
| Staff were clear about their roles and responsibilities. | Yes |
| There were appropriate governance arrangements with third parties. | Yes |
| There are recovery plans in place to manage backlogs of activity and delays to treatment. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The provider and practice management team met every 2 months to discuss risk and performance, this included issues relating to the building and reviewing staffing arrangements. In July 2023, the provider had reviewed their governance arrangements and identified clear lead roles to manage different areas for example, performance, teaching and supervision, substance misuse, and staffing. | |

Managing risks, issues and performance

The practice mostly had clear and effective processes for managing risks, issues and performance.

| | Y/N/Partial |
|--|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Yes |
| There were processes to manage performance. | Yes |
| There was a quality improvement programme in place. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Partial |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Yes |
| Explanation of any answers and additional evidence: | |

- The provider had implemented systems and processes to manage risk. From meeting minutes we viewed we saw that issues relating to risk were discussed during governance and clinical meetings.
- However, we found some processes were not fully effective and required improvement.
- For example, we found that while there was an IPC audit process in place, not all issues relating to the cleaner’s cupboard or the carpets had been identified nor actions added to the action plan.
- A health and safety risk assessment had been completed, and although it considered most major risks, it was not a comprehensive risk assessment. For example, there was a process in place for calibrating some medical equipment, however not all equipment that required calibrating had been identified and included on the schedule.
- The provider took immediate action, following the inspection, to improve the cleaner’s cupboard and arrange deep carpet cleaning and calibration of any medical equipment that required it.

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. | Yes |
| Performance information was used to hold staff and management to account. | Yes |
| Staff whose responsibilities included making statutory notifications understood what this entailed. | Yes |

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. | Yes |
| The provider was registered as a data controller with the Information Commissioner’s Office. | Yes |
| Patient records were held in line with guidance and requirements. | Yes |
| Patients were informed and consent obtained if interactions were recorded. | Yes |
| The practice ensured patients were informed how their records were stored and managed. | Yes |
| Patients were made aware of the information sharing protocol before online services were delivered. | Yes |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Yes |
| Online consultations took place in appropriate environments to ensure confidentiality. | Yes |
| The practice advised patients on how to protect their online information. | Yes |
| Staff are supported to work remotely where applicable. | Yes |

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. | Yes |
| The practice had an active Patient Participation Group. | Yes |
| Staff views were reflected in the planning and delivery of services. | Yes |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff we spoke with told us they had opportunities to provide feedback when they identified areas that needed improvement, the provider listened and supported them to improve processes and/or implement new systems. • Staff told us learning from complaints, significant events and clinical audits was shared with them to help improve the quality of care. • The provider monitored patient feedback through patient surveys, complaints, NHS UK website and through the friends and family test. • The provider was working with the PCN to help improve access and deliver a wider range of services that would benefit their patient population. | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| We did not speak to any members of the Patient Participation Group (PPG), however, from meeting minutes we viewed we saw the practice met regularly with the PPG to update them on topics such as performance, results from the national patient survey, and to provide an update on what action the practice was taking to improve access. |

| Any additional evidence |
|---|
| From evidence we viewed and from staff we spoke with, we found the provider sought feedback from a range of sources and worked collaboratively with others to improve quality and safety. |

Continuous improvement and innovation

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

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Yes |
| Learning was shared effectively and used to make improvements. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider had implemented systems to learn from incidents and complaints and reduce the risk of them occurring again.• We saw evidence of clinical audits that had led to improved safety and effectiveness of care and treatment.• The provider collected feedback from medical students and trainee GPs. They used feedback to help improve their training program. Feedback we viewed was positive about supervisors, that they were knowledgeable and supportive. Where suggestions were made, these were implemented by the provider.• The provider was aware of the challenges they had with appointment and telephone access and were taking appropriate action to improve this. For example, they had started to use a new patient website from August 2022, which gave patients faster online access to the practice, and reduced the demand on the telephone lines. They continued to work with the PCN to monitor patient use and make improvements to the website as needed. The practice was actively signposting patients (where appropriate) to the local pharmacist if their needs could be responded to faster. | |

Examples of continuous learning and improvement

- The provider worked with the PCN to deliver targeted health promotion services that met their patient populations needs.
- This included a diabetes education program that delivered holistic interventions to patients with raised blood glucose levels and BMI greater than 30 and included advice on:
- One of the GP partners was leading on another project being delivered by the PCN. The Health and harmony project. This project included Women aged 25 to 40 years with depression, a BMI over 30 and who smoked. The project included clinical interventions from GPs, social interventions, dietary and weight management advice and interventions such as cooking, gardening and other social activities.
- The PCN tracked patient outcomes for both projects and shared these with the practice, so they could monitor patient's progress.
- The provider told us of future projects and clinical audits they planned on carrying out in the future to further improve the health of their patients.
- The provider shared quality improvements with others. For example, one of the non-medical prescribers had developed a clinical search and template to monitor that patients on high risk medicines received

the required monitoring and follow up. The clinical search and template was shared with the PCN and implemented by other GP practices within the PCN.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

Glossary of terms used in the data.

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