

# Care Quality Commission

## Inspection Evidence Table

### Lodge Road Surgery (1-7445318115)

Inspection date: 3 March 2022

Date of data download: 16 February 2022

**Overall rating: Good**

**Safe**

**Rating: Good**

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	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"><li>• There were designated clinical and non-clinical safeguarding leads in place to oversee safeguarding.</li><li>• All staff had completed the required level of safeguarding training relevant to their role and were clear on the procedure to follow if they had a safeguarding concern.</li><li>• There were safeguarding registers in place which was regularly reviewed and maintained. We reviewed patient records and found they were coded appropriately and contained clear information on their record.</li></ul>	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> <li>There were comprehensive policies and procedures for safeguarding children and vulnerable adults. These were reviewed and updated to reflect any changes and were accessible to staff.</li> <li>We reviewed meetings and could evidence that safeguarding concerns were discussed in practice meetings.</li> <li>Clinicians followed up children and young people who did not attend appointments both at the practice and for secondary care appointments.</li> <li>Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks were in place for staff as part of pre employment checks and annual risk assessments for their renewal had been carried out. This included enhanced and standard DBS checks based on the role and responsibilities of the job. DBS checks identify 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.</li> <li>The practice was able to demonstrate that they were accessing health visitors and social work teams during COVID-19. We saw evidence to demonstrate that the practice actively engaged in serious case reviews and had produced reports and attended case conferences for safeguarding in a timely manner. In addition, the local safeguarding team had access to the practice's clinical system to add useful updates or concerns, which was regularly reviewed by the practice.</li> </ul>	

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 Public Health England (PHE) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We reviewed five personnel files including clinical, non-clinical and recently employed staff. We found all the appropriate checks had been carried out prior to employment such as references, proof of identity and staff vaccinations in line with relevant guidance.</li> <li>Induction checklists were in place for each staff member tailored to their role.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 5 May 2021	Yes
There was a fire procedure. Date of fire risk assessment: 5 May 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The provider was located in modern purpose built premises. We saw evidence that an up to date risk assessment that had been carried out for the building.</li> <li>Fire alarm testing took place each week. The practice had three staff identified as fire wardens and they had received training to support them in this role.</li> </ul>	

- Staff had access to a health and safety policy, which had been reviewed in the last 12 months. We saw a health and safety maintenance check, a disability risk assessment and legionella risk assessment had been carried out in May 2021. Calibration checks for equipment and testing of portable appliances was undertaken in January 2022 to ensure they were fit for purpose and were in good working order.

## 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.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 15 June 2021	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
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"> <li>• To ensure the safety of both staff and patients during COVID-19 pandemic, clinical staff were given time between seeing each patient to clean their consulting rooms.</li> <li>• The practice kept up to date with the changing advice and guidance from NHS England to ensure the GP practice offered a Covid Secure environment.</li> <li>• Staff had completed infection prevention training relevant to their role and there was an infection control lead in place.</li> <li>• Control of substances hazardous to health (COSHH) risk assessment was carried out in September 2021.</li> <li>• We observed the general environment to be clean and tidy with the layout and facilities of the premises in line with COVID-19 guidance for infection prevention and control.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	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:

- There was a system in place to manage staff absences to ensure that adequate cover arrangements were in place for non-clinical and clinical staff.
- During COVID-19 a review of roles was undertaken, and all non-clinical staff were trained in dual roles to ensure staff were upskilled to cover all areas of work. This ensured that work could be covered without loss of continuity.
- All staff had undertaken basic life support and sepsis training and understood the procedures to follow when encountering deteriorating or unwell patients.

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• A system was in place to ensure all patient information including documents, laboratory test results and cytology reports were reviewed and actioned in a timely manner.</li> <li>• There was a process in place for the summarising of patient records, this included a system for flagging records which required prioritising.</li> <li>• A clinician was allocated protected time to make sure pathology results were checked and actioned where appropriate. As part of our inspection we reviewed the practice clinical inbox and found test results had been managed promptly.</li> </ul>	

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.45	0.71	0.71	Variation (positive)
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). (01/10/2020 to 30/09/2021) (NHSBSA)	3.4%	6.8%	9.8%	Significant Variation (positive)
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 (01/04/2021 to 30/09/2021) (NHSBSA)	4.57	5.17	5.32	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	113.7‰	135.2‰	128.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	0.44	0.68	0.63	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	3.0‰	8.6‰	6.7‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

Medicines management	Y/N/Partial
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 structured medicines reviews for patients on repeat medicines.	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 high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England 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 PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had appropriate systems in place for the safe prescribing and monitoring of medicines and were supported by a clinical pharmacist in areas of medicines optimisation.</li> <li>• Prescribing data showed the practice to be in line or above in areas such as antibiotics and hypnotic prescribing.</li> <li>• There was clinical oversight for all requests for medicine changes and a clear process was in place to demonstrate what actions had been taken.</li> <li>• The practice told us they had recently employed a dedicated clinical administrator to support medicines management and ensure patients received reminders to attend the practice for the appropriate monitoring.</li> <li>• During our remote clinical review of patients prescribed Methotrexate, we found a total of eight patients were prescribed this medicine and we found that the appropriate monitoring was in place for all patients.</li> <li>• We carried out a clinical search to identify how many patients had been prescribed novel oral</li> </ul>	

Medicines management	Y/N/Partial
<p>anticoagulants (NOACs). We reviewed a random sample of records and found the appropriate monitoring was in place.</p> <ul style="list-style-type: none"> <li>Other clinical searches carried out on disease modifying drugs and hypnotic medicines showed that appropriate monitoring was largely carried out, however the practice had difficulties in engaging with some patients. For example, 12 out of 519 patients were overdue blood tests and some were overdue reviews; however we saw evidence in the clinical records that the practice had made efforts to encourage patients to attend for monitoring and the practice had taken action to reduce patient quantities and duration of therapy on hypnotics.</li> <li>We found that blank prescriptions were kept securely and there was a system in place to record the serial numbers.</li> <li>We reviewed Patient Group Directions (PGD's) for the administration of medicines and found these authorisations had been read and signed off appropriately.</li> <li>The practice had a stock of medicines available in the event of a medical emergency and there was a system in place to monitor stock levels and expiry dates. A risk assessment had been completed for medicines not stocked by the practice. Two suggested medicines not stocked by the practice were added to the risk assessment during the inspection.</li> <li>Medicine fridges were monitored to ensure they were maintained at the correct temperatures for storing vaccines and other relevant medicines.</li> </ul>	

#### 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:	3
Number of events that required action:	3
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had a significant event monitoring policy and reporting template in place. Staff we spoke with were aware of how to report and record significant events and most were able to share an example and the action taken.</li> <li>The practice promoted an open and no blame culture for staff involved with a significant event and told us events were very much seen as a system to learn and improve. Significant events were a standing agenda item and discussed at clinical meetings and practice meetings.</li> </ul>	



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

Event	Specific action taken
Missed referral. Patient called the practice for an update on their referral and this had not been actioned.	The practice apologised to the patient and actioned the referral immediately. The practice implemented a new tracking system which was audited weekly to avoid this happening again.
Fridge power failure.	All vaccines in the fridge were destroyed safely. Patients were contacted and appointments were re-arranged. Data loggers were purchased for inside the fridge and an additional small fridge was purchased as an additional measure.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had a system in place for the recording and acting on safety alerts. These were received by the practice manager and reviewed by the lead GP who disseminated this to the appropriate staff. All safety alerts were discussed in clinical and practice meetings.</li> <li>As part of our clinical searches we reviewed a safety alert that recommends that two particular medicines are not taken together as the potential side effects is increased when co-prescribed with another. We identified nine patients who had been prescribed both medicines and found that two patients had been reviewed; however, the remaining patients required further action. We raised this issue with the provider who took immediate steps during our inspection and provided evidence that those patients we had identified had been contacted and appropriate action taken.</li> </ul>	



## Effective

## Rating: Good

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

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>Clinical staff were able to describe how they kept up to date with best practice. We saw evidence that the practice held weekly clinical meetings as part of best practice.</li><li>Our review of the practice clinical system identified appropriate management of patients care and treatment. We saw evidence that patient records were of a good standard and contained relevant information. For example, safety netting, shared decision making, and an agreed care plan was clearly documented in line with best practice.</li><li>Provider policies and procedures were in place which promoted evidence-based practice. The practice had invested in technology to support their clinical system in areas such as medicines management, clinical safety, and best practice.</li><li>At the time of our inspection systems were being strengthened to ensure clinical registers and coding issues had been reviewed and updated accurately. Where we found that some reviews</li></ul>	

for patients were overdue, the practice had a system in place to prioritise those patients deemed more high risk and were working through their call and recall.

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. During our inspection we found that the practice had carried out 82 reviews for patients over 75 years in the last three months.
- 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 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 palliative care register and was supported by an end of life hub team.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- The practice had worked throughout the COVID 19 restrictions to provide care and treatment for patients with long-term conditions.
- Our remote clinical reviews could evidence that the practice had completed 364 medication reviews in the last three months.
- Patients with long-term conditions were offered a structured 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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. A dedicated clinical administrator had been employed to support the call and recall of patients for medication reviews.

- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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. The practice had purchased 10 ambulatory blood pressure monitors to support patients in monitoring hypertension.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan. The practice had carried out 22 asthma reviews in the last three months.
- We found that patients with long term conditions were well managed. Where patients were overdue blood tests, we could evidence that steps were being taken to engage patients to attend for review.

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) (01/04/2019 to 31/03/2020) (NHS England)	65	73	89.0%	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) (01/04/2019 to 31/03/2020) (NHS England)	60	65	92.3%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	61	65	93.8%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	61	65	93.8%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles,	50	62	80.6%	Below 90% minimum

mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)				
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

### Any additional evidence or comments

- The practice had not met the minimum 90% for two out of five childhood immunisation uptake indicators. The practice told us they were aware that they had high levels of deprivation within the practice area and a migrant population which created challenges to engage patients to attend for immunisations. To increase uptake the practice had followed up non-attenders through home visits and recruited a dedicated clinical administrator who worked closely with the practice nurse to recall patients for immunisations and proactively follow up non-attenders.
- There was a recall system in place so that nursing staff and a clinical administrator would follow up on children that did not attend for their immunisations. If the child did not attend on three occasions this was brought to the attention of the practice's safeguarding lead for further review and action.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 30/06/2021) (Public Health England)	72.1%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	52.2%	55.7%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	60.2%	57.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE)	15.4%	50.3%	55.4%	Tending towards variation (negative)

#### Any additional evidence or comments

- Practice performance for the uptake of cervical screening was below the 80% national target. The practice was aware of difficulties in their patient population and were working through their recall processes to engage patients to attend for screening. A cancer champion was in place who had engaged with MacMillan Cancer Support prior to the pandemic. We saw that information was available on the noticeboard to support patients living with cancer as well as opportunistic screening undertaken for patients attending for other routine appointments. Unverified data reviewed at the time of our inspection for the uptake of cervical screening in women age 25-49 year was 84% and women age 50-64 years was 83%.
- We reviewed the number of new cancer cases treated as this was below local and national levels. The practice told us that during this time there had been issues in the data accuracy during the pandemic. The practice had undertaken its own audit and reviewed both qualitative and quantitative data regarding delays in cancer diagnosis. The audit found examples where patients had opted to be seen earlier than the two week wait appointment, for example, in secondary services, as well as patients opting for a private referral to reduce the wait time during the pandemic. The audit demonstrated that they had taken action to consider if any quality improvements were needed to optimise early cancer diagnosis.

## 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

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

An audit was completed for the prescribing of Beta-Blockers in patients with asthma due to updated guidance advising that beta-blockers should usually be avoided in asthma patients unless prescribed under secondary services. The audit identified five patients on the asthma register who were prescribed beta-blockers. The practice found that two out of five patients were incorrectly on the asthma register and three patients were reviewed by a clinician and offered a safer alternative prescribed medicine.
The practice carried out a two cycle audit for patients who had a history of Gestational Diabetes to ensure they had their HbA1c (blood sugar) recorded, and an annual screening programme was in place as it was recognised that patients with Gestational Diabetes are seven times more likely to develop type 2 diabetes after their pregnancy. The first audit identified 27 patients eligible and only 5 had a blood test in the last 12 months. The remaining 22 patients were referred for blood tests. The second cycle audit identified 28 patients eligible and 26 patients had received appropriate monitoring. The first audit identified that a significant set of patients on the Gestational Diabetes register had not been having appropriate follow up testing on an annual basis to assess for risk of diabetes, the second audit showed improvement had been made in recalling patients annually for testing.

## 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• Staff had completed training identified as mandatory by the provider. This included level three adult and children safeguarding training for clinical staff. There was oversight of training which was monitored by the management team to ensure all staff were up to date with their training needs.</li><li>• During the pandemic a review of roles had been undertaken for non-clinical staff so they were trained in dual roles and could provide cover where needed.</li><li>• Staff told us as part of their development, they were given protected time to attend any training and development courses and were encouraged to do this.</li><li>• We found that staff appraisals had been completed and we saw evidence that staff members were supported with development opportunities. For example, health care assistants were trained to perform additional duties such as suture removal, flu vaccines and B12 injections.</li><li>• The lead nurse is a mentor and supports student nurses for placements at the surgery.</li></ul>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes



Explanation of any answers and additional evidence:

- The practice worked with multidisciplinary teams and across the primary care network (PCN) to coordinate care effectively for patients. Staff were knowledgeable about services available and signposting arrangements to support patients' needs. We saw evidence of appreciation from stakeholders in the practice's approach to working with multi-disciplinary teams across the locality.

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had a programme of quality improvement to ensure patients received the appropriate reviews and monitoring.</li> <li>As part of long-term conditions reviews the nursing team supported patients to improve their health by living a healthier lifestyle.</li> <li>The practice was supported by a social prescriber, through their local Primary Care Network, to support patients in managing their health and wellbeing.</li> </ul>	

## Consent to care and treatment

**The practice always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Clinical staff we spoke with understood the requirements of the Mental Capacity Act and used templates to support capacity assessments for example, when undertaking Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions.</li> <li>• Our clinical searches identified that DNACPR decisions made were appropriately and clearly recorded.</li> </ul>	

## Caring

**Rating: Good**

### 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-judgmental 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"><li>• Staff understood the needs of the population and had received appropriate training in providing a chaperone service as well as promoting equality and diversity.</li></ul>	

Patient feedback	
Source	Feedback
NHS UK	Feedback on the NHS UK choices website was mixed with patients reporting that the practice was friendly, nice helpful, thorough and understood concerns and worries whilst others reported poor staff attitude.
Compliments	We saw that compliments had been received by the practice and shared with all staff members. These related to staff being a great team, helpful and supportive to its patients

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	76.9%	86.3%	89.4%	Tending towards 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 (01/01/2021 to 31/03/2021)	74.8%	85.0%	88.4%	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 (01/01/2021 to 31/03/2021)	92.4%	93.8%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	65.8%	76.8%	83.0%	Tending towards variation (negative)

### Any additional evidence or comments

The practice were aware there were areas within their patient survey results that were below local and national averages. The provider consulted with staff and analysed feedback and had developed an action plan for improvement.

The action plan included the following:

- Complete customer service training for staff to help improve patients experience when making an appointment.
- Review the allocated appointment time to allow patients more time to discuss their issues.
- Obtain further feedback from patients if they felt happy with the decisions and treatment following consultation.
- Continue to build trust and understanding with patients through training.

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

### Any additional evidence

The provider was aware of the latest published results from the national GP patient survey and had taken action to make improvements to patient satisfaction scores. For example, results of the survey were discussed at staff meetings to increase staff awareness and training was undertaken to improve the patients experience. The practice had conducted their own patient survey in December 2021 and planned to repeat the survey in order to help monitor the effectiveness of the actions implemented on patient satisfaction scores. Results from the in-house patient experience survey reported that 93% of patients were satisfied that the clinicians took the time to listen and explain patients concerns and issues and 91% were happy that the reception team looked after them in a professional and courteous manner.

### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Resources were available such as language line, pictorial materials and a hearing loop for patient support. The electronic records included coding to assist staff to identify patients who may require additional support, such as patients with carers, a learning or physical disability, literacy, hearing or sight impairment.</li></ul>	

### National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	86.7%	90.3%	92.9%	No statistical variation

### Any additional evidence or comments

An action plan had been completed to address areas of low performance within the patient survey results. The practice had analysed data for the past four years and found that overall results had improved from the previous year, but the practice also identified that the results did fluctuate year on year. An inhouse patient survey had been completed to try and monitor the patient experience further.

	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"> <li>Interpreting service were available for patients if required. The practice also employed staff who were able to speak a number of languages to engage with the diverse population registered at the practice.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 192 patients who were carers which represented 3.4% of the practice list size.
How the practice supported carers (including young carers).	The practice had a nominated carers champion who was involved in developing support offered to carers. Advice and support was available on the practice website and information was available in the practice. All patients registered as a carer were eligible for a carer's assessment, an annual health check and flu vaccination.
How the practice supported recently bereaved patients.	Bereavement information was available on the practice website and in the practice. The practice sent a condolence card to families and would contact them for further follow up where necessary.

## 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:	

# 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.	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"> <li>There were arrangements in place for interpreting services should patients request this. The practice website included a translation service to assist patients further.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:00am - 6:30pm
Tuesday	8:00am - 6:30pm
Wednesday	8:00am – 8:00pm
Thursday	8:00am - 6:30pm
Friday	8:00am - 6:30pm
Appointments available:	
Monday	9:00am – 1:00pm and 3:00pm – 5:45pm
Tuesday	9:00am – 1:00pm and 3:00pm – 5:45pm
Wednesday	9:00am – 1:00pm and 2:00pm – 7:45pm
Thursday	9:00am – 1:00pm and 3:00pm – 5:45pm
Friday	9:00am – 1:00pm and 3:00pm – 5:45pm
	Patients were also able to access evening appointments through another site locally.



#### 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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 6pm on a Monday, Tuesday and Friday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8pm on a Wednesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a primary care network.
- 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 and longer appointments were available.
- The practice was able to book same day appointments for patients to attend a local site should they present with any respiratory related illnesses.

## Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
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	Yes
There were systems in place to support patients who face communication barriers to access treatment	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"><li>• During the COVID-19 pandemic, requests for a face to face appointments were triaged by a clinician.</li><li>• At the time of inspection, the practice was offering a range of appointment types to patients.</li><li>• The practice had invested in technology to support the telephone and appointment system. For example, queuing and monitoring software and the upgrade of the practice self-arrival and waiting room screens.</li><li>• The practice had identified that some of their patient population who may be digitally excluded. At the time of our inspection the practice was in the process of hosting an event to engage with patients registered at the practice to increase their confidence in using digital technology to reduce barriers in obtaining an appointment.</li></ul>	

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	45.6%	N/A	67.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	45.9%	62.7%	70.6%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	50.4%	62.2%	67.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	49.9%	76.3%	81.7%	Significant Variation (negative)

Any additional evidence or comments
<p>The provider was aware of the latest published results from the national GP patient survey and had taken action to make improvements to patient satisfaction scores. The COVID pandemic attributed to some of the changes to appointment availability within the practice, however we saw evidence where this was discussed and reviewed to improve patients experience.</p> <p>An action plan had been implemented to address some of the challenges where results were lower than local and national averages. This included:</p> <ul style="list-style-type: none"> <li>• The practice continued to advertise appointment times available on the practice website and notices around the practice.</li> <li>• The introduction of online GP Triage to increase access to the practice and to allow patients to send requests.</li> <li>• An increase in the number of GP appointments available. An additional 15 appointments per week were created for the lead GP.</li> <li>• Increasing the offer of later appointments during the week for the working population.</li> </ul>

Source	Feedback
NHS UK	Patients reported difficulties in obtaining an appointment, whilst others were happy with the quick response by the practice. We found that the practice had responded to all comments received on NHS UK.

## 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.	14
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice complaints leaflet was available in the practice and explained what the practice will do in response to a complaint received.</li> <li>The practice held a log of written and verbal complaints made to the practice. We looked at the records of three complaints reported within the last 12 months. Records showed that these complaints had been acknowledged and, after investigation, replied to in writing.</li> <li>Records showed that learning from complaints had been shared with relevant practice staff at practice meetings. We also found that five compliments had been shared with staff in the past 12 months.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complained regarding their consultation with a clinician.	The practice apologised to the patient. The complaint was investigated by the practice and reviewed with the clinician for further learning and development.
Patient complained of difficulties obtaining an appointment.	The practice apologised to the patient who was given information on the appointment system in place. The patient was also informed of additional appointments available within the locality to book on the day.

## 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"><li>• Leaders at all levels demonstrated experience, capacity and capability needed to deliver quality and sustainable care. Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture.</li><li>• Leaders had an understanding of issues, challenges and priorities in their service, and beyond and had produced a five-year business plan which had been updated during the pandemic and took account of the changing landscape and delivery of primary care.</li><li>• The leadership team understood the challenges within their local population which included high levels of deprivation, health inequalities, a diverse population and barriers to accessing healthcare. They were committed in meeting the needs of the population and worked collaboratively to achieve outcomes for their patient population.</li><li>• The lead GP was the appointed clinical director for the practice's primary care network (PCN). The leadership team were aware of the changing landscape of primary care and were keen to develop collaborative working relationships with other local practices to improve patient care and outcomes.</li><li>• The leadership team were committed in involving all staff to shape and improve the service and there was evidence of effective planning to address areas of concerns through action planning with progress against delivery.</li><li>• Staff told us that the GP partners and practice management were approachable and always took time to listen to all members of staff.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	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"> <li>• Leaders told us about their vision to provide an unrivalled healthcare service, admired for everything we do.</li> <li>• The practice's values were: Collaboration, Patient-focused, Respect and Innovation.</li> <li>• The strategy and supporting objectives and plans were aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.</li> <li>• The practice held regular meetings and kept their strategy under review to ensure progress was being achieved.</li> <li>• Patient care was seen as the priority for the practice and staff we spoke to understood the vision of leaders and they also understood their role in working towards the vision.</li> </ul>	

## 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"> <li>• There were clear systems and processes in place to ensure effective care and to drive quality improvement. The practice had clear policies and procedures accessible to all staff, for example, whistleblowing, safeguarding and health and safety.</li> <li>• The practice focused on the needs of patients and worked together to achieve the best possible outcomes for patients. We saw evidence that the practice processes and systems which ensured patients and staff were kept safe from harm were properly embedded. We saw strong team-working and support across all areas and a common focus on improving the quality and sustainability of care and patient's experience.</li> </ul>	

- Staff told us they felt respected, supported and valued in their roles, there was an open door policy and they were able to share any concerns with the leadership team.
- The practice had whistleblowing and duty of candour policies in place and a nominated freedom to speak up guardian to support staff if they wanted to raise an issue.
- We looked at a sample of training records for five members of staff, all had completed equality and diversity training.
- Leaders and managers were approachable and had processes, policies and human resource procedures in place to address behaviour and performance that was inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when we discussed with staff how they would respond to incidents and complaints. They were aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes for providing all staff with the development they required, this included appraisal and career development conversations.
- All staff had received an annual appraisal within the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were given protected time for professional development and evaluation of their clinical work.
- Practice meetings took place which provided an opportunity for staff to discuss issues.
- There was a focus on staff wellbeing with regular dialogue and communication on changes during COVID-19. In addition, all staff had undertaken a personalised risk assessment and had access to external services for wellbeing support during COVID-19.

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

Source	Feedback
Staff interviews	Staff we spoke with told us that they felt supported and had opportunities to raise any issues and concerns. They also told us that they felt listened to, there was an open door policy and it was a great place to work.

## 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Structures, processes and systems to support good governance and management were established, clearly set out, understood and effective. Appropriate policies, procedures and activities were embedded and monitored to ensure effectiveness. Staff were able to access the policies through shared governance systems.</li> </ul>	



- Governance arrangements were proactively reviewed and reflected best practice, for example, infection control, recruitment, health and safety.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. The practice had clear systems of governance with named leads to oversee the governance of the service. This was clearly visible for patients and staff on the practice noticeboard.
- Evidence reviewed from clinical records and discussions with staff demonstrated patients care and treatment was delivered with effective governance structures, systems and clinical oversight.
- Quality improvement was in place to ensure governance structures were regularly monitored as part of best practice. The practice had identified historic issues with coding and had invested in a system to support medicines management and clinical excellence. At the time of our inspection work was underway to embed new process and review issues identified with historical coding.
- The practice had systems in place to ensure all staff were clear on their roles and responsibilities. Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place.
- Staff we spoke with were clear about their role and responsibilities. Communication was effective and organised through structured, minuted meetings. Governance and performance management arrangements were proactively reviewed and reflected best practice.
- All clinicians met regularly to discuss work prioritisation and vulnerable patients as well as difficult cases and current events. There was a good relationship with community teams to ensure patients received effective co-ordinated care.
- There had been a re-structure of non-clinical roles during the pandemic. Staff we spoke to told us that they were clear what was expected of them.
- There was an open culture and clear learning culture within the practice, the systems for reporting and investigating incidents and complaints were integral to the team to share learning. The practice encouraged the reporting of incidents, however small, to identify ways in which the practice could continually improve.

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	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.	Yes
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 practice had a range of policies, procedures and risk assessments in place, for example, business continuity, health and safety, and infection control.
- The practice had arrangements to identify, manage and mitigate risks which was regularly kept under review with action plans to measure performance and progress against delivery.
- There was a demonstrated commitment to best practice performance and risk management systems and processes. The practice reviewed how they functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed openly to make improvements.
- There was a programme of clinical auditing in place to monitor quality and implement improvements and learning was shared with staff.
- There were systems in place to review the capacity, demand and waiting times to ensure quality and sustainability was regularly assessed and monitored.
- The practice had a business continuity plan in place which was held on site and available to all staff.
- A system of quality assurance monitoring had been put in place to ensure patients who needed follow up were not lost. In addition, the practice used a risk stratification tool to code and support them in their recall processes to determine the frequency of reviews. To support this there was a dedicated staff member to support annual reviews.

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• During the pandemic all patients that requested to see a clinician were first given a telephone appointment. Following the telephone review, the clinician would make a clinical decision if a face to face appointment was required.</li> <li>• During the easing of lockdown, the practice had opened its doors and face to face appointments were available for all patients without the need of a telephone consultation if required.</li> </ul>	

- Infection control processes had been strengthened and extra cleaning schedules had been implemented to ensure cleaning was carried out at frequent intervals. Clinical staff were given extra time between patients to clean their consultation rooms.
- COVID-19 risk assessments had been completed for each member of staff, personal protective equipment (PPE) was available and in use by staff and patients entering the practice, in addition to temperature checks being taken on arrival.

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice could evidence they had systems and processes established to regularly review information and performance. This included the use of the Quality and Outcomes Framework (QOF), audits and action plans to improve clinical performance and outcomes for patients.</li> <li>Systems were in place to ensure risk assessments were completed on a regular basis to manage and mitigate risks.</li> <li>A range of safety mechanisms had been implemented to ensure risks were mitigated. This included software, risk trackers and audits to ensure information was accurate and timely and a comprehensive range of risk assessments to ensure patient safety.</li> <li>There were designated leads and areas of responsibility within the practice for example, clinical governance, prescribing, safeguarding, first aid, complaints, infection control and a carers champion. This information was available to patients on the practice noticeboard in reception.</li> </ul>	

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	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
Explanation of any answers and additional evidence:	

- The practice used NHS approved software when consulting with patients remotely.
- Staff had received training and had access to guidance when undertaking remote consultations.
- The practice had policies to support them on information governance and cyber security. There was a named partner who lead on areas of IT.

## 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Staff were able to raise suggestions with the leadership team and in practice meetings.</li> <li>• The practice had a Patient Participation Group (PPG) and a meeting was last held in June 2021. Due to the pandemic the practice had not held any further meetings however we saw evidence that they were engaging with patients by holding an informal event with refreshments which included a guest speaker.</li> <li>• The practice had strong links across the locality. They continued to engage with Healthwatch, the local Clinical Commissioning Group and safeguarding leads within the locality.</li> <li>• The practice was the lead practice across the primary care network and supported the delivery of local services including the extended access hub and COVID-19 vaccine programme.</li> <li>• The practice had taken a leadership role in its health system to identify and proactively address challenges and meet the needs of the population.</li> <li>• We saw many examples of appreciation from stakeholders such as Public Health England, CCG, external colleagues and the local head of safeguarding for the practice's contribution, knowledge, experience, collaborative and contribution to the work across the locality.</li> </ul>	

## Continuous improvement and innovation

**There were 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:	

- The practice was committed to ensuring health inequalities were tackled and were currently reviewing projects to address inequalities within the practice and across the PCN. For example, the practice had identified patients who are digitally excluded and were supporting patients by providing digital literacy workshops. The practice had introduced new coding to identify digital exclusion and support patients by providing training to build confidence and reduce barriers in accessing the service.
- Innovation was shared and there was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There was a strong record of sharing work locally and nationally.
- The practice made use of learning events, incidents and complaints to improve the service.
- The practice had set up a system of quality monitoring searches as part of their pandemic recovery plan. The risk stratification tool supported them to identify patients needing follow up and to enable risks to be considered when prioritising patients for reviews and monitoring.

### Examples of continuous learning and improvement

- During COVID-19 the practice worked with community leaders and delivered vaccines to communities who may otherwise have been difficult to reach. In addition, the practice had been instrumental in supporting the local COVID vaccination centre. Some staff had trained and became vaccinators and the practice were also able to offer vaccinations at the practice if required. The practice had set up and operated a local amber site across three PCN's which included a population of 150,000 patients. We saw evidence of letters of appreciation from Public Health England and the CCG who recognised the practice's contribution in engaging the community during the pandemic and contributing to Sandwell winning a national public health award for its Covid vaccination programme. In addition, the practice had engaged with PCN's across Sandwell to support them in providing vaccines within their practices.
- The practice was a mentoring practice for student nurses and offered placements in primary care. During the last 12 months they had offered 10 places for student nurses.
- The leadership team were committed in delivering and modelling best practice. At the time of our inspection the practice manager had completed a Prince 2 project management course to support their role in addition to practice partners being enrolled on the institute of leadership and management level 7 (ILM) course.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

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