

# Care Quality Commission

## Inspection Evidence Table

### The Queens Road Partnership (1-545225942)

**Inspection date:** Remote interviews 14 & 19 April 2022 and site visit 12 April 2022

**Date of data download:** 06 April 2022

## Overall rating: Good

Overall, the practice is rated as good and requires improvement for providing safe care. The practice had addressed the concerns relating to the management of medicines (including high risk medicines), safety alerts and identifying patients with undiagnosed long-term conditions. We found some minor issues related to recruitment and emergency equipment and medicines which impacted the rating for the safe key question.

## Safe

## Rating: Requires Improvement

The practice was rated as requires improvement at our last inspection due to concerns about the management of patient safety alerts and patients prescribed high risk medicines and medicines that require regular review. We found at this inspection that action had been taken to address these issues however:

- Recruitment checks had not been completed for all staff
- There were issues with the practice defibrillator and staff were uncertain of the location of one emergency medicine.
- All staff reported issues with staffing levels although the practice was taking steps to recruit additional administrative and reception staff and a health care assistant.

Consequently, the service remains requires improvement for providing a good service.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y

<b>Safeguarding</b>	<b>Y/N/Partial</b>
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>At our previous inspection we found that the practice had a written protocol for repeat prescribing of medicines which required monitoring, but managers were not checking to ensure that clinicians were following the protocol to ensure appropriate monitoring has been carried out prior to prescribing high risk medicines.</p> <p>At this inspection we undertook a search of patient taking high risk medicines. We found that all but two patients prescribed warfarin were up to date with monitoring and one patient prescribed Leflunomide had all monitoring completed except for blood pressure monitoring. The patient on Leflunomide had been contacted to ask that they attend the surgery for blood pressure mentoring. The patients on warfarin were all being monitored by secondary care. There was only one patient where it did not appear that the clinician had checked monitoring was up to date prior to issuing medication; although results from secondary care were in the clinical record the day that warfarin was last prescribed. The next test due date had not been recorded for only two patients. This was a significant improvement from our last inspection.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
<p>There were some gaps in the recruitment files of staff whose files we reviewed. For two staff members we found that there was a signed offer letter but no signed contract. One staff member had no reference and no copy of qualifications on file.</p> <p>A member of clinical staff did have a record of their immunity to common communicable diseases on file. However, this stated that they were not immune to measles or rubella and there was no risk assessment in place to say that this had been considered.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken.	Y

Date of last assessment: 31 July 2021	
There was a fire procedure.	Y
Date of fire risk assessment: 31 July 2021 Actions from fire risk assessment were identified and completed.	Y
Legionella risk assessment: June 2021	
The practice had last undertaken portable appliance testing and calibration of medical equipment in March 2021. Further calibration of medical equipment was completed in August 2021. Further calibration was scheduled to be completed again on 27 April 2022.	

## Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 8 April 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
The minutes of one meeting we reviewed focused on the need for staff to self-isolate if they contracted covid. Staff were told that this would need to be reviewed as the “new variant is not that bad”. The requirements at the time were for healthcare staff to self-isolate if they contracted covid 19.	

## Risks to patients

### There were systems to assess, monitor and manage risks to patient safety though all staff spoken to acknowledged that .

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Partial
All staff we spoke with mentioned difficulties around staffing particularly within the reception and administrative team. Minutes of meetings we reviewed outlined increasing workloads for non-clinical staff. The practice told us that they were actively trying to recruit new staff and that one member of staff was starting shortly and that they were recruiting for another nonclinical staff role. We were also told that the practice nursing team had also experienced a high rate of turnover but that the practice had	

recruited a practice nurse in the middle of last year and were training another nurse to be a general practice nurse. The practice was also in the process of recruiting a healthcare assistant to provide further support the clinical team.

Though the practice had all emergency equipment; the supply of one emergency medicine was not located with the others and the defibrillator battery was not connected to the defibrillator and it was unclear if the battery was working properly.

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
At our last inspection we found there was no effective system in place to ensure patient information received from secondary care, including test results, were not always considered prior to prescribing medication. At this inspection we found that the practice had developed systems to ensure that consideration of test results and other relevant information from secondary care was considered prior to prescribing in all but one instance.	

## 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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.48	0.57	0.76	Variation (positive)

Indicator	Practice	CCG average	England average	England comparison
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2021 to 31/12/2021) (NHSBSA)	13.6%	9.4%	9.2%	Tending towards variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2021 to 31/12/2021) (NHSBSA)	5.90	5.61	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	109.7‰	72.6‰	129.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	0.39	0.41	0.62	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	7.0‰	4.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y

Medicines management	Y/N/Partial
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.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p data-bbox="65 1043 1517 1155">At our last inspection we found that the practice was not following their repeat prescribing policy for medicines that required follow up and monitoring. We found that patients prescribed some high-risk medicines had not had all of the monitoring tests undertaken within the required time period.</p> <p data-bbox="65 1211 1517 1503">At this inspection we found that all patients on high risk medicines whose records we reviewed were up to date with their monitoring, only one patient prescribed warfarin did not have documented consideration of the results received from secondary care recorded in their notes prior to prescribing and two did not have their next test date recorded. This was a significant improvement from our previous inspection. The practice told us that they ran fortnightly searches on their clinical system to ensure that medicines monitoring had been completed and patients overdue monitoring were contacted. The practice held fortnightly quality assurance meetings and we saw that the monitoring of patients on high risk medicines was a standing consideration.</p> <p data-bbox="65 1559 1517 1704">We asked the practice about the above average rates of prescribing of certain antibiotics including co-amoxiclav, cephalosporins and quinolones, though the rate was lower than at our previous inspection. The practice told us that they had two or three patients who were prescribed this as directed by secondary care and another who was allergic to other antibiotics.</p> <p data-bbox="65 1760 1517 2007">We reviewed the practice emergency medicines supply. We found that one medicine (glucagon – used to treat hypoglycaemia) was not present within the store of medicines. We asked staff where this medicine was located on the day of our visit and were told that they knew there was a supply within the practice but did not know where it was. We asked one of the partners the following day who again believed this was kept with the store of emergency medicines. We were subsequently told that this was stored in the nurse's fridge and that this was stated on the checklist of the emergency medicines. The practice also did not have a supply of dexamethasone (used to treat croup in infants). However, the</p>	

Medicines management	Y/N/Partial
practice had risk assessed this and had stock of an alternative (prednisolone) that was easier to source and lasted longer.	
We reviewed the internal data logger for the practice's vaccine fridge. This showed that temperatures had gone above 8 degrees Celsius (the maximum temperature for vaccine storage) on both 4 and 7 of April 2022. We were provided with fridge temperature checking logs which showed that this coincided with a stock take and a vaccine delivery.	

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

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	3
Number of events that required action:	3

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Double administration of covid vaccine	Checked with local vaccine hub to ensure no adverse reaction. Informed and monitored patient. Protocol put in place to prevent similar incidents happening in the future
Delay in referral	Patient apologised to. Referral sent. Discussion at clinical meeting, decided that clinicians need to task referral during consultation rather than wait till end of surgery.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
At our last inspection we found that the system for actioning safety alerts was not effective.	
At this inspection we undertook a search of patients prescribed medicines that had been the subject of safety alerts and found no concerns.	



## Effective

## Rating: Good

The practice is rated as good for providing effective care after having been previously rated requires improvement. The change in rating is due to the improvements the practice has made in their systems to access, act on and record information from secondary care and also due to systems and processes that have been put in place to identify patients with undiagnosed long-term conditions. The review of patient records indicated that the standard of clinical care was good and that patients were receiving care and treatment which met their needs. However, there was limited evidence of quality improvement activity and there were issues with coding of patients with chronic kidney disease and a small number of patients with chronic obstructive pulmonary disease.

*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/ was not delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
At our last inspection we found that the practice did not have effective systems to identify patients with commonly undiagnosed conditions, including diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.	
At this inspection searches and records reviews of patients with possible undiagnosed conditions indicated that patients were having appropriate follow up and review. The only issue identified was,	



despite receiving appropriate care and treatment, we found that patients with chronic kidney disease and a small number of patients with COPD were not correctly coded on the practice's clinical system. We were told that these patients would be reviewed following our inspection to ensure that the correct codes would be added. The practice told us that they had regular quality assurance meetings and ran searches on a monthly or fortnightly basis to identify patients with undiagnosed long-term health conditions.

## 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. The practice tracked the number of patients who required a review for severe frailty regularly.
- 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. Performance for flu vaccination was regularly monitored.
- 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. 30 out of 39 patients with a learning disability had received a health check within the last 12 months and the remaining number of patients were tracked and followed up fortnightly.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. We were told that the practice had an administrative lead for palliative care patients who contacted these patients fortnightly to check if they required further support. Other patients classed as vulnerable were contacted monthly.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. Patients on the mental health register were, we were told, contacted every two months to check on their wellbeing and that they were taking their medicines as the patient record system did not flag patients who failed to request repeat prescriptions. Patients who required further support or who were not taking their medication would be referred to a GP.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- Reviews of records showed that the quality of care provided to patients with long term conditions was proactive and of a good standard.
- 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.
- 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. We saw that regular searches were run, and results discussed in the practice's fortnightly quality assurance meetings. However we saw that coding for patients with COPD and CKD needed to be improved.
- 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.
- Patients with asthma were offered an asthma management plan.

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) (01/04/2020 to 31/03/2021) (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) (01/04/2020 to 31/03/2021) (NHS England)	56	71	78.9%	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) (01/04/2020 to 31/03/2021) (NHS England)	62	71	87.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England)	61	71	85.9%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England)	71	83	85.5%	Below 90% minimum

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

### Any additional evidence or comments

Performance against targets for childhood immunisations had declined slightly since our last inspection. Staff at the practice told us that this could have been related to turnover of nursing staff at the service and due to people being reluctant to attend the surgery during the pandemic.

However, the current practice nurse, employed in June 2021 felt; that there had been an improvement in uptake. We were told of additional challenges including general hesitancy amongst the local population. To combat this the practice had appointed a dedicated administrative lead who reviewed lists of patients who required or were overdue immunisations. They would call these patients once or twice a week in an attempted to book them in for appointments. If patients could not be contacted by phone, the practice would send three text messages and then a letter. Patients who expressed any concerns about vaccines during calls were booked appointments with the practice nurse who could provide counselling on the benefits of vaccination or assurance regarding any concerns. The practice nurse said that they would ensure that next vaccination appointments were booked immediately following the last. The practice also had a nurse trainee who, though not currently administering childhood vaccinations, would be able to support the practice with this once fully trained.

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: 30/09/2021) (Public Health England)	66.3%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	59.9%	54.2%	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)	54.6%	60.5%	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)	45.7%	52.0%	55.4%	No statistical variation

### Any additional evidence or comments

The practice performance for cervical screening was below target at our last inspection. Performance remained below target at this inspection. Again, we asked the practice about efforts made to improve performance in this area and were told of a similar recall system outlined above for childhood immunisations; including a dedicated administrative lead. The lead could book hesitant patients with both a nurse or doctor who could provide assurance or answer questions about the procedure. If after counselling, patients still do not want to participate in the screening programme, the practice would ask patients to sign a disclaimer to confirm this. The practice held a dedicated Tuesday evening cervical screening clinic in an effort to accommodate working patients who may not be able to attend the practice

at other times. We saw that cervical screening was a standard agenda item at the practice's fortnightly quality assurance meetings.

## Monitoring care and treatment

**There was limited monitoring of the outcomes of care and treatment.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

<p>The practice had completed a number of clinical audits related to clinical care that we reviewed at our last inspection which demonstrated quality improvement including ones related to the prescribing of lithium, direct oral anti coagulants and sodium valproate. However, all of these audits were slightly over two years old. We were also provided with an undated single cycle audit related to hypertension in pregnancy.</p> <p>The practice had completed one two cycle audit within the last two years related to the prescribing of Non-steroidal anti-inflammatory drugs (NSAID). Though this was a two-cycle audit with action points stemming from each cycle; there was no evidence of quality improvement.</p> <p>The practice had undertaken improvement activity following our last inspection to improve the monitoring and the quality of care for patients. This was evident from our review of patient records.</p>
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## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	n/a
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
A staff member whose file we looked at had filled in an appraisal form but there was no record of any appraisal discussion.	

## 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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Although the patients whose records we review all appeared to be received effective care and treatment which met their needs; there were some patients with certain long term conditions, particularly chronic kidney disease and a small number of patients with chronic obstructive pulmonary disease, who did not have this coded on their record. This could create a potential risk of patients not receiving timely follow up or treatment or receiving relevant information to enable them to live healthier lives.	

### Any additional evidence or comments

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
We saw from discussions at the practice's last quality assurance meeting that they currently had no patients with a DNACPR decision recorded. However, discussions with staff indicated that appropriate steps would be taken to comply with legislative requirements.	

## Well-led

## Rating: Good

At our last inspection we found that systems and processes to monitor patients on high risk medicines, act on patient safety alerts and identify patients with undiagnosed long-term conditions. We found that these systems had improved. We found minor issues related to medical emergencies and recruitment and there was limited evidence of clinical audit which resulted in quality improvement.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

### Vision and strategy

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

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

### Culture

**The practice had a culture which drove high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y



Staff had undertaken equality and diversity training.	Y
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Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff feedback	Feedback from staff indicated that they were happy to raise concerns and felt that there was good leadership within the practice. However, all feedback from all staff referred to lack of sufficient staff in the reception and administrative team.

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
At our last inspection we found that there were issues with the practice's governance framework, specifically around the management of high-risk medicines and safety alerts. At this inspection we found that the practice had taken steps to strengthen oversight in these areas and records reviewed indicated that revised governance arrangements were effective in ensuring that patients had safe, effective care and treatment.	

## Managing risks, issues and performance

**Although there had been improvement in the management of risks related to the management of medicines; risks around recruitment, infection control and the management of emergencies required refinement.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
At our last inspection we found that the practice did not have effective systems to mitigate risks associated with medicines management. At this inspection we found that these issues had been	

addressed. However, we found minor concerns in relation to risks associated with recruitment and the management of emergencies.

There was evidence of quality improvement activity which had been used to address concerns raised following our last inspection. Clinical audits that we reviewed were either historic or did not result in quality improvement.

## **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.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y

## **Appropriate and accurate information**

### **There was a demonstrated commitment to using data and information proactively to drive and support decision making.**

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
At our last inspection we found that the practice did not have systems in place to ensure that they had access to and documented consideration of information prior to prescribing high risk medicines. We found that this had been largely addressed at this inspection with only a single patient prescribed a high-risk medicine who did not have references to results documented in their record before a prescription was issued.	

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

## Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Feedback from Patient Participation Group.

Feedback
We saw minutes from a recent PPG meeting where results of an internal patient survey were discussed. The PPG fed back that they wanted to see improvements in access arrangements at the surgery.

## Continuous improvement and innovation

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

	Y/N/Partial
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There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y
<p>The practice had acted on the basis of feedback from our last inspection to make improvement to the quality of care provided to patients. However, there was limited evidence of recent clinical audit.</p> <p>The practice had developed a system to enable secure remote MDT working during the pandemic that was adopted across the CCG.</p> <p>The practice was a training practice and was currently training a new practice nurse.</p>	

## 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.

