

## Inspection Evidence Table

Grayshott Surgery

(1-547544787)

Inspection Date: 4 May 2023

Date of data download: 28/04/2023

## Overall rating: Requires improvement

The practice is rated requires improvement overall because of significant gaps in risk identification, management and mitigation, gaps in staff training, and infection control.

### Safe

### Rating: Requires improvement

We rated the practice as requires improvement for providing safe services because:

- Risk assessments were either not in place or not recorded appropriately and mitigating actions were not always acted on in a timely manner.
- Infection control audits were not clearly documented nor actions taken to address findings. We saw that some areas of the premises were not clean.
- Significant events were being recorded but learning could be shared more widely to support improvement.
- Patient group directions were not always appropriately authorised.

#### Safety systems and processes

**The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y

There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
Explanation of any answers and additional evidence:	
The practice is at the border of two counties and have two child protection leads, one for each county.	
At the time of our inspection the practice was not meeting regularly with health visitors but were trying to restart these meetings. The practice has told us that since our inspection they have met with the health visitor and have a future meeting in the diary. They also told us that they planned to meet quarterly with health visitors and social workers.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment:	April 2023
There was a fire procedure.	Y
Date of fire risk assessment:	March 2023
Actions from fire risk assessment were identified and completed.	N
Explanation of any answers and additional evidence:	
The practice did monthly health and safety walk arounds which were recorded, however actions identified were not always followed up. For example, loose cables were highlighted on the last four walk arounds as an issue. The practice had a health and safety action tracker but not all identified actions were on the tracker, for example loose cables.	
The practice had carried out a fire risk assessment, however this had not been completed by a competent person and had failed to identify significant risks. For example, gaps in the ceiling which would allow fire to spread more easily between floors and large accumulations of paper in the loft space. The practice told us that they had a previous fire risk assessment from 2019 but were unable to provide evidence of this during our inspection.	

The practice had identified two members of staff as fire marshals, however they had not received any training for this role. We also found that 5 out of 10 receptionists and 3 out of 9 GPs had not completed fire safety training in the last two years as required by the practice. The practice had not been carrying out regular fire drills. The practice had carried out a fire drill 28 April 2023 but this only involved approximately 50% of staff. There was no record of any previous fire drills.

The practice has told us that since the inspection a fire risk assessment has been carried out by an external company, which has identified some mitigating actions. The practice told us that have already taken action to address the most urgent of these and have a plan to complete the remaining actions within the required timescales. The practice also told us that since our inspection fire marshal training has been completed and the next fire drill has been planned.

The practice did not have a current electrical installation condition report for the premises. An electrical installation condition report must be carried out every five years to ensure the property is electrically safe.

The practice has told us that since the inspection they have had an electrical installation condition report carried out.

The practice was carrying out annual water testing for Legionella but there was no legionella risk assessment in place and therefore a lack of understanding of what other mitigations should be in place. The lead for Legionella had not received any training to undertake this role. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

The practice has told us that since the inspection they have completed a Legionella risk assessment and the lead for Legionella had received appropriate training. They also told us that water temperatures were now monitored monthly and recorded in a logbook.

Control of substances hazardous to health (COSHH) risk assessments were not in place for the COSHH chemicals used by the practice staff. The chemicals used by the cleaning company had COSHH risk assessments in place. The lead for COSHH had not received any training to undertake this role. There was one mercury sphygmomanometer in the practice but there was no COSHH risk assessment or mercury spill kit available to staff. The practice has told us that since the inspection they have carried out a review of all required COSHH risk assessments and that the COSHH lead has started appropriate training. They told us they have a plan to have all the COSHH risk assessments completed in a timely manner. The practice also told us that they now have a mercury spill kit on site available to staff.

**Infection prevention and control**

**Appropriate standards of cleanliness and hygiene were not met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out.	Partial

Date of last infection prevention and control audit:	February 2023
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice was undertaking regular infection prevent and control (IPC) audits, however these were not clearly documented. There were no clear action plans in place to address concerns raised by the audits. The audit results in August 2022 were 48% which indicated very poor standards of IPC. The audit undertaken in February 2023 was annotated that nothing had changed and for some areas of the practice such as staff and patient toilets, the outcome was marked as failed.</p> <p>We found that actions identified by infection control audits carried out in August 2022 had not been addressed at the time of our inspection. For example, the GP and registrar rooms were not appropriately cleaned, there was dust and cobwebs on shelves, and skirting boards were dirty. The practice had changed their cleaning company six weeks prior to our inspection but had failed to monitor their work appropriately" to "The practice had changed their cleaning company 6 weeks prior to our inspection and informed us the contractors were in a process of addressing the concerns around cleanliness.</p> <p>We found there were gaps in infection control training. For example, 3 out of 10 receptionists and 2 out of 9 GPs had not completed infection control training.</p>	

### Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y

### 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.	Partial
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.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a system for summarising new patient notes, however the practice had a large backlog, with some notes waiting up to a year to be summarised. In order to reduce the risk of this backlog, each set of notes had key points, such as immunisations, summarised when the notes arrived at the practice. The practice had also trained a second member of staff to help with summarising to address the backlog. There was a tracker system in place to identify where each set of notes was stored so that if the original notes were needed they were easily accessible. The practice was unable to confirm how long they expected it to take to clear the backlog.</p> <p>We reviewed outstanding test results awaiting review and found that they were all less than a week old. However, we found one abnormal urine result that had not been acted upon. We raised this with the practice who confirmed the matter had already been dealt with by the time we raised it. They told us this was due to the bank holiday and staff who worked part time. The practice told us how they would change their systems going forward to ensure this did not occur again.</p> <p>We also reviewed a global view of tasks awaiting action in the practice's clinical system and found a backlog of 7,406 tasks dating back to May 2022. We reviewed 3 of these tasks and found no evidence that they had been actioned or completed. The practice was unaware of this backlog when we raised it with them.</p> <p>Following the inspection, the practice reviewed these tasks and found that the majority, over 7,100, were autogenerated administrative tasks regarding the deregistration process, where patients had left the practice, and had no impact on patient care. Of the remaining tasks 30 were over 3 months old and another approximately 270 tasks were being actively monitored by staff. The practice told us they had reviewed all 30 tasks which were over three months old and either completed them or put plans in place where required, to action the tasks.</p>	

### **Appropriate and safe use of medicines**

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.94	0.79	0.86	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2022 to 31/12/2022) (NHSBSA)	12.2%	8.9%	8.1%	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 (01/07/2022 to 31/12/2022) (NHSBSA)	6.02	5.85	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	101.8‰	76.8‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	1.12	0.66	0.56	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	8.8‰	5.5‰	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).	N
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y

There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	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
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	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.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y

A CQC GP Specialist Advisor accessed the practice's systems, with the practice's consent, to undertake searches of clinical records. These searches were indicative of the number of patients at risk due to a lack of monitoring or diagnosis and further investigation of the patient record was needed to assess risks. We sampled a select number of patient records, where any risks were potentially identified, to assess the risks for these individual patients. Our searches indicated that the practice had an effective process for monitoring patients' health in relation to the use of medicines including high risk medicines and medicine reviews.

Medicine reviews - We reviewed 5 individual patient records and found 3 medicine reviews which were satisfactory and 2 which were not sufficiently comprehensive. The provider had recorded medicine reviews that had been conducted without documenting the outcomes. Reviews were not comprehensive in that they did not address all required monitoring or changes to treatment. For example, a medicine review had been recorded when only medicines used to treat diabetes had been reviewed, rather than all the medicines that the patient was prescribed.

High Risk Medicines and Disease-modifying antirheumatic drugs (DMARD) medicines – The provider was able to demonstrate that it was safely prescribing medicines to patients where specific, frequent monitoring was required. We reviewed 5 patient records for patients who were prescribed a medicine used to treat rheumatic diseases and found they were monitored appropriately.

The clinical searches identified a total of 1,476 patients taking a medicine or group of medicines which may be used to treat high blood pressure. Of these we identified 59 patients (approximately 4%) who appeared to be overdue appropriate monitoring. We sampled 5 of these and found that there were problems with the care for all 5 patients. When we spoke to the practice they told us they were aware not all patients who were taking this medicine had received appropriate monitoring but they already had a programme in place to address this. We saw evidence that the number of patients who had not received appropriate monitoring had reduced over time, reducing from 139 to 59 in the last 6 months.

We reviewed 4 patient group directions (PGDs) and found that only 1 was authorised appropriately. We found 2 PDGs which were signed by 1 nurse after the doctor had authorised them and 1 had no authorising signature or date.

**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:	9
Number of events that required action:	8

Example of significant event recorded and actions by the practice.

Event	Specific action taken
The wrong patient was identified when the practice was contacted by the ambulance service.	The practice has changed its procedure to include the date of birth is checked as well as the name of the patient.

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
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed one MHRA alert and found 7 patients who appeared to be on the incorrect dose of an antidepressant. We reviewed 5 of these records and found that 4 patients did not have any record of the risk being discussed with them. When we spoke with the practice they demonstrated that these patients were aware of the risks and on an appropriate dose.</p> <p>The practice also told us that they were utilising their in-house dashboard to monitor this alert and over the last 2 months had reduced the number of potentially affected patients from 12 to 7.</p>	

## Effective

## Rating: Requires improvement

We rated the practice as inadequate for providing safe services because:

- There were significant gaps in staff training.
- Patients were not always followed up in a timely manner following asthma exacerbations.
- Patients who may have diabetes were not always monitored appropriately.

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

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
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.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
Patients were not always followed up following asthma exacerbations and a small number of patients who may have diabetes were not always monitored appropriately.	

## 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.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example, before attending university for the first time.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition, according to the recommended schedule.
- The practice 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.
- We reviewed the care plans for 4 patients who were on the palliative care register and found that these were all satisfactory.

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. 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.
- 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.

A CQC GP Specialist Advisor accessed the practice's systems, with the practice's consent, to undertake searches of clinical records. These searches were indicative of the number of patients at risk due to a lack of monitoring or diagnosis and further investigation of the patient record was needed to assess risks. We sampled a select number of patient records, where any risks were potentially identified, to assess the risks for these individual patients. Our searches identified a small number of potentially affected patients and we found that the practice had an effective process for monitoring patients' health. The practice had developed an in-house dashboard to maintain oversight of patient monitoring and drive improvement. The practice also had a number of quality improvement projects in place, for example to improve monitoring of patients with hypothyroidism.

Our review of clinical records showed:

Eighteen patients with blood tests indicating they may have undiagnosed diabetes which had not been identified or recorded in their records. From these we reviewed 5 records, of which 4 were not reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. We asked the practice for clarification regarding these patients and they told us that these patients had either already been recalled for further testing or were already being monitored.

Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care. The clinical searches identified a total of 56 patients who had been prescribed 2 or more courses of rescue steroids in the last 12 months. We sampled 5 of these and found that patients were not being monitored after asthma exacerbations or increasing treatment.

Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance. We saw there were 525 patients with hypothyroidism and our searches identified that 20 may not have received the appropriate monitoring or review. We reviewed a random sample of 5 records and found that 5 had not had their hypothyroidism managed in line with recommended guidance.

When we spoke to the practice they told us they were aware not all patients who were taking this medicine had received appropriate monitoring but they already had a quality improvement project in place to address this. We saw evidence that the number of patients

who had not received monitoring had reduced over time, reducing from 35 to 20 potentially affected patients in the last 6 months.

We saw there were 61 patients with chronic kidney disease stage 4 or 5 (CKD4 or 5) and our searches identified that 9 may not have received the appropriate monitoring or review. We reviewed a random sample of 5 records and found that only 1 had not been managed in line with recommended guidance.

When we spoke to the practice they told us they were aware not all patients diagnosed with CKD 4 or 5 had received appropriate monitoring but they already had a quality improvement project in place to address this. We saw evidence that the number of patients who had not received monitoring had reduced over time, reducing from 15 to 9 potentially affected patients in the last 6 months.

We saw there were 628 patients with diabetes, the searches identified that 28 patients may not have received the appropriate monitoring or review. We reviewed a random sample of 5 records and found they all had their diabetes managed in line with recommended guidance.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	68	73	93.2%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	83	94	88.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	83	94	88.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	82	94	87.2%	Below 90% minimum

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	81	101	80.2%	Below 90% minimum
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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 was trying to increase uptake of childhood immunisations by promoting these to parents. Although the practice strongly encouraged parents to bring their children for vaccination they respected the view of parents who chose not to vaccinate their children.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	76.1%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	76.4%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (9/30/2022 to 9/30/2022) (UKHSA)	72.4%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	60.2%	56.7%	54.9%	No statistical variation

### 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
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Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice had carried out a range of audits which demonstrated improvements over the last two years, including antibiotic prescribing, high risk drug monitoring, fast track referrals, double appointment usage and non-steroidal anti-inflammatory prescribing with protein pump inhibitors.</p>	

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a programme of learning and development but we found there were significant gaps in staff training. For example, 3 out of 10 receptionists had not completed adult safeguarding training, 2 receptionists had not completed safeguarding children training and 4 receptionists and 1 out of 9 GPs had not completed information governance training. We also noted that there was no record of any reception or administration staff or 3 out of 9 GPs completing display screen equipment training.</p> <p>The practice told us that since our inspection they had made changes to how staff mandatory training was monitored, with arrangements for escalation if non-compliance is</p>	

identified. They also told us that now all new staff complete their mandatory training in their first week of employment.

Non-clinical staff had not had access to regular appraisals, however we saw that staff had appraisal dates booked in for May and June 2023.

The practice told us that since our inspection all staff who were due an appraisal have completed these.

**Coordinating care and treatment**

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a self-service blood pressure monitor in the reception area where patients could also measure their height and weight. Patients were asked to give the printout from the machine to reception, where the details would be recorded onto their patient records. There was a protocol in place for reception staff so that if the blood pressure was over a certain level it was flagged to the duty doctor.</p>	



The practice referred to social prescribing schemes, including weight management and smoking cessation services.

**Consent to care and treatment**

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Y

**Responsive**

**Rating: Good**

**Responding to and meeting people's needs**

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	

Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with community services to discuss and manage the needs of patients with complex medical issues.
- Nurse appointments were available on some early mornings for school age children, so that they did not need to miss school.
- All parents or guardians calling with concerns about a child under 2 were offered a same day appointment when necessary.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available with GPs in the evening Monday to Friday and with GPs and nurses during the day on Saturday.
- 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.

### Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y

Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence:  Patients could request appointments through an online form and they could also call the practice or attend in person.	

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	73.6%	N/A	52.7%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	67.1%	58.3%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	66.8%	57.1%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	78.4%	73.9%	71.9%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	The practice received 8 reviews in the last 12 months, 2 of these were positive and 1 was negative about accessing appointments.

**Listening and learning from concerns and complaints**  
**Complaints were listened and responded to and used to improve the quality of care**

<b>Complaints</b>	
Number of complaints received in the last year.	8
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example of learning from complaints.

Complaint	Specific action taken
Patient complained that reception staff would not give their blood tests results to them.	The practice reviewed their protocol and provided refresher training for receptionists to explain to patients that a doctor must approve the results before they can be released to the patient.

## Well-led

## Rating: Requires improvement

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

- There were significant gaps in the identification, management and mitigation of risk.
- Staff were not always aware of their roles and responsibilities in lead roles.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels. However, leaders had not identified risks in relation to the premises.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:  Leaders were not aware of the lack of risk identification, management and mitigation regarding the premises.	

### 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.	Partial
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
Explanation of any answers and additional evidence:	
There was a strong focus on the well-being of staff. However, there was a lack of risk assessment and mitigation around health and safety, staff training, fire safety, infection control and legionella. This meant there was a lack of focus on the safety of staff.	

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

Source	Feedback
Staff feedback	Staff told us that managers and GPs were approachable and they felt well supported by them. Staff also told us that they found the practice a friendly place to work and they enjoyed coming 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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Partial

Explanation of any answers and additional evidence:  
 There was a large backlog of patient notes awaiting summarising and the practice had taken action to reduce the risk from the notes not being fully summarised. However, when we asked the practice, they were unable to provide a date by which they expected to clear this backlog.  
 We also found there was a large backlog of tasks in the clinical system that hadn't been completed. The practice was unaware of the backlog but immediately following the inspection they took action to review these tasks and provided an action plan of how they would clear the outstanding tasks in a timely manner.

**Managing risks, issues and performance**

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	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.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were significant gaps in identifying, managing and mitigating risks. For example, control of substances hazardous to health, fire safety, infection control and legionella. Leaders in the service were not aware of these gaps and were not always aware of their responsibilities in these areas. Assessments had not always been undertaken by a suitably trained and competent person which meant the practice could not be assured that all the risks had been identified. We did see evidence that the practice was trying to improve their management of risk by putting in place action trackers but these did not contain all of the actions identified.</p> <p>Staff had received some training in preparation for major incidents. However, staff were not adequately trained in preparation for fire risks. There was not an adequate fire risk assessment in place, not all staff had received training in fire safety, fire wardens had not received training for their role and the practice only had 1 recorded fire evacuation drill which only involved approximately 50% of the staff.</p>	



**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.	Partial
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:  Leaders in the service were not aware of the backlog in global tasks which meant they had not been monitoring performance in this area.  Appraisals had not been conducted for non-clinical staff, however we saw evidence that appraisals were booked in May and June for all non-clinical staff. Clinical staff had received appraisals in the last 12 months.	

**Governance and oversight of remote services**

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

### **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

### **Continuous improvement and innovation**

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

### **Examples of continuous learning and improvement**

The practice had developed an in-house dashboard to monitor and drive improvement in prescribing and medical monitoring.

There was a comprehensive audit programme which supported improvement. For example, antibiotic prescribing and high-risk drug monitoring.

## Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands. The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

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

The following language is used for showing variation:

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

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