

# Care Quality Commission

## Inspection Evidence Table

The Vale Practice

(1-548015254)

### Inspection Date:

Date of data download: 14/11/2023

## Overall rating: Good

### Context

The practice is based in the London Borough of Haringey and delivers care to a patient population of approximately 10,410 patients. Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the sixth lowest decile (sixth of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 74% White, 9% Black, 7% Asian, 6% Mixed, and 3% Other.

The latest available data for age distribution of the practice population show the patient age groups are:

- Young People 19%
- Working Age 74%
- Older People 8%

In response to patient requests the practice had made more pre-bookable appointments available. It was in the process of automating the process for appointment booking, to enable patients to choose an appointment that suited them. This change would also help to cut down waiting times on the phone.

**Safe**

**Rating: Good**

## Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). <sup>1</sup>	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role. <sup>2</sup>	Partial
Explanation of any answers and additional evidence: 1. Staff underwent induction training on starting with the practice. However, when we looked at staff training records, administrative staff had not completed the induction training template. 2. Two out of three staff records we reviewed contained no evidence of staff vaccination status.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment:	20.02.2023
There was a fire procedure.	Y
Date of fire risk assessment:	13.03.2023
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	

**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.	Y
Date of last infection prevention and control audit:	16/1/23
The practice had acted on any issues identified in infection prevention and control audits. <sup>1</sup>	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
1 We were provided with a fully completed infection prevention and control audit completed in January 2023. There was an attached action plan identifying two issues. The action plan confirmed both issues had been resolved.	

**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
Explanation of any answers and additional evidence:	

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. 1	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
Explanation of any answers and additional evidence: 1 Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.	

### 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) (01/07/2022 to 30/06/2023) (NHSBSA)	0.75	0.65	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2022 to 30/06/2023) (NHSBSA)	11.1%	8.8%	7.8%	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 (01/01/2023 to 30/06/2023) (NHSBSA)	5.73	5.54	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	62.0‰	61.9‰	129.5‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.29	0.53	0.54	Tending towards variation (positive)

Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	4.3‰	6.0‰	6.8‰	No statistical variation
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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
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	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 medicines that require monitoring (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
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
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. <sup>1</sup>	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence, including from clinical searches.	
<p>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 was trending towards negative, with higher prescribing than local and national averages. However, the practice was, overall, a lower prescriber of all antibiotics than the national average. The practice explained that it has a large number of patients who had researched their issues and persuasively requested specific antibacterial medicines. In addition, the practice told us, patients attending the out of hours GP Hub locations were more often prescribed co-amoxiclav, cephalosporins and quinolones.</p> <p><sup>1</sup> The practice held a range of medicines for use in an emergency. However, whilst it had agreed in a clinical meeting not to keep stocks because of the proximity of other sources, it did not have a written risk assessment for not keeping an emergency supply of Opiates – Diamorphine, Morphine or Pethidine for injection. These medicines are required for use in case of severe pain including myocardial infarction (heart attack).</p>	

**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:	4
Number of events that required action:	4
Explanation of any answers and additional evidence:	

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

Event	Specific action taken
A patient was sent for tests, however, the practice was not informed of the outcome until a clinician followed up on the issue.	The practice discussed the issue and the practice manager immediately contacted the laboratory for the test results. The incident was recorded for discussion at the next clinical meeting.
A patient was sent for a blood test. The results were abnormally high and should have triggered a need to call the patient in for a face to face appointment the same day. However, although the results were recorded, the patient was not contacted until 15 days later.	The practice reviewed the issue and agreed that in similar circumstances clinicians must be raised with the Duty doctor and contact made with the patient. If contact could not be achieved the matter should be handed over to the out of hours team to follow up. This information was circulated to staff and marked to be provided to all new starters.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. 1	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
1 Safety alerts were received via email, and notifications were promptly forwarded to clinicians. They were discussed in clinical meetings and the clinical pharmacist reviewed alerts against patient records. Alerts and any corresponding actions were recorded in a shared Excel sheet, which was readily accessible to all team members.	

# Effective

# Rating: Good

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

## Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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.	Y
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

## Effective care for the practice population

Findings
<ul style="list-style-type: none"> <li>Those identified received a full assessment of their physical, mental and social needs. Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li> <li>The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li> </ul>

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

Our review of patients with long term conditions found that in most cases patient care was of a good standard:

- The majority of patients with asthma were being well managed. We identified 15 patients with asthma (out of a total registered number of 458 patients) who had been prescribed 2 or more courses of rescue packs. 'Rescue packs' containing oral steroids are sometimes prescribed for patients with asthma, to keep at home and use as part of a personal asthma management plan when experiencing an exacerbation of symptoms. The practice was calling those patients in for review and told us it also gave patients steroid treatment cards. A Steroid Treatment Card (blue) carries a series of instructions for the patient on the use of the medicines and informs healthcare professionals of the details of the steroids prescribed.
- We found 10 patients with hypothyroidism (out of 271 registered patients) who had not undergone thyroid function test monitoring for 18 months. Without monitoring of thyroid function patients are at risk of complications including angina and heart attack. The practice was able to show that some patients had been asked to attend for reviews, while others were receiving treatment within secondary care.
- Five patients were identified as having a potentially missed diagnosis of diabetes. On review of those patient records we found three had been coded as pre-diabetic, one had been referred to secondary care, the diabetes prevention programme, and one was recorded as being at risk of diabetes.
- We reviewed three patients who had been prescribed more than the recommended maximum number of SABA inhalers. NICE Guidelines state: "Patients using more than one short-acting beta2 agonist (SABA) inhaler device a month should have their asthma urgently assessed and action taken to improve poorly controlled asthma.". On review we found that the practice had dealt appropriately with the patients' individual circumstances giving rise to the excess prescribing. No concerns were identified in the care of these patients.
- Forty-six patients with diabetic retinopathy had a latest HbA1c greater than 74mmol/l (out of 211 registered patients). However, a detailed review of those patient records we looked at, showed the practice had dealt appropriately with patients' individual circumstances. HbA1c is a measure of diabetic control. Patients with an HbA1c level of 75mmol/l or higher are at greater risk of developing further complications affecting their eyesight.
- 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.



- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae 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)	121	133	91.0%	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)	116	127	91.3%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	116	127	91.3%	Met 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)	117	127	92.1%	Met 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)	116	137	84.7%	Below 90% minimum

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

### Any additional evidence or comments

The practice had met the minimum 90% target for four out of five childhood immunisation measures that CQC reviews. However, its performance for immunising 5 year old children against measles, mumps and rubella (two doses of MMR) was below the 90% target.

The practice told us:

- It contacted the parents or legal guardians (collectively “parents”) of children due to have childhood immunisations to remind and encourage them to attend.

- Where parents failed to respond to invitations to attend, the practice placed alerts onto its system so any parents attending with children could be offered opportunistic immunisation, and appointments were available throughout the week.
- Some patients originated from other countries, many refused immunisation on behalf of their children, for varying reasons, including:
  - some had received the immunisation abroad.
  - A number of patients regularly returned abroad so were difficult to contact.
- Some patients moved out of the area without informing the practice they had left.
- A number of patients refused on grounds of belief.
- it undertook calls and re-calls of patients, including sending texts, and letters to remind parents to bring in their children for immunisations.

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)	47.8%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	67.1%	N/A	70.3%	N/A
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)	64.3%	55.7%	54.9%	No statistical variation
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). (6/30/2023 to 6/30/2023) (UKHSA)	67.3%	N/A	80.0%	Below 70% uptake

### Any additional evidence or comments

The practice detected and referred new cancer patients at a rate above the national average.

The practice's performance was below the national cervical screening target of 80%. It told us:

- A number of eligible patients originated from other countries and travelled abroad for cervical screening.
- Appointments were available throughout the week, patients attending the surgery for other reasons could, if appropriate, be offered screening during their visit, and the practice actively promoted uptake of screening.
- Female sample takers were available (nurse and GPs), and all sample takers had received training for the role.
- Alerts were placed on the system and eligible patients were opportunistically offered appointments.
- The practice nurse spoke to any patients who were reluctant to engage with screening.
- The practice undertook calls and re-calls of eligible patients, including sending texts, and letters to remind patients to attend for screening.

### Monitoring care and treatment

**The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: The practice had audited its prescribing of nitrofurantoin. Nitrofurantoin is an antimicrobial medicine often used to treat recurrent urinary tract infections.  The first cycle of the audit, in May 2023, found 10 patients being regularly prescribed the medicine. Review of these patients records showed there was no documented evidence of explanation of risks associated with long-term nitrofurantoin use or the need for monitoring. The practice met and agreed that all patients should receive an explanation of the risks and need for monitoring.  The audit was re-run in November 2023. At that time the practice found all of the patients identified in the first cycle had been invited for review, to include a discussion of the risks and need for monitoring. Though not all had attended the reviews.  The second cycle also identified three patients who had commenced long-term use of nitrofurantoin, However, none of these patients records showed evidence of discussion of risks or the need for monitoring. The practice reviewed the findings and developed a new protocol to be added to the locum pack. It also assigned the need for regular monitoring to one of its clinical pharmacists. The practice also arranged to review the issue in a clinical meeting.	

### 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.	Y

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

### 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

### Consent to care and treatment

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

	Y/N/Partial
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Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Y
Explanation of any answers and additional evidence, including from clinical searches: 1 Our clinical review of notes identified a number of cases where a DNACPR decision had been recorded. During our site visit we saw evidence which confirmed that where possible the patients' views had been sought and respected and information had been shared with relevant agencies.	

## Caring

**Rating: Good**

### Kindness, respect and compassion

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

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

### Patient feedback

Source	Feedback
.	.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	90.7%	83.5%	85.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)	90.6%	81.5%	83.8%	No statistical variation

The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	96.7%	91.9%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	81.7%	68.8%	71.3%	No statistical variation

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

### Any additional evidence

The practice routinely monitored its Friends and Family Test results. The most recent test found that 47 (94%) out of 50 patients responding would recommend the practice to friends and family.

### Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Easy read materials were available.	

Source	Feedback
Interviews with patients.	<p>During our inspection visit, we spoke to five patients. All patients responded positively to questions about involvement in decisions about their care. Amongst the comments we received from patients were:</p> <ul style="list-style-type: none"> <li>• “Yes, even the nurses are brilliant”.</li> <li>• “Yes, especially [named doctor] who is amazing”.</li> </ul> <p>Asked for their overall impression of the practice, all patients responded positively, comments included:</p> <ul style="list-style-type: none"> <li>• “Great practice and they have managed the transition (partner change) well”.</li> <li>• “No issues with the practice”.</li> <li>• “Good practice, I am happy to be a patient here and I understand other practices have issues but I don’t see any here”.</li> </ul>

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### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	94.1%	88.5%	90.3%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 174 carers, representing 1.6% of the practice population.
How the practice supported carers (including young carers).	The practice contacted carers on an annual basis to offer them flu vaccinations and ensure their contact information was up to date. In addition, the social prescriber contacted carers to offer them additional services, including assistance in accessing benefits.  Young carers are signposted to local dedicated young carer services.
How the practice supported recently bereaved patients.	Bereaved patients are signposted to local bereavement services, which were provided on-site at the practice.

### Privacy and dignity

**The practice respected patients' privacy and dignity.**

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

# Responsive

# Rating: Good

## Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.1	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.2	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
1 the practice had developed, and worked with local stakeholders to offer patients a range of services. These included, a free weight management course, links for new patients to access support and mental health support for adults and children. The practice also had a social prescriber who was able to support and direct patients to a range of local services.	
2 Translation services were available for patients whose first language was not English.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:30am to 1.00pm and 2pm to 8.00pm*
Tuesday	8:30am to 1.00pm and 2.00pm to 8.00pm*
Wednesday	7:30am to 1.00pm and 2.00pm to 6:30pm*
Thursday	8:30am to 1.00pm and 2.00pm to 6:30pm*
Friday	7:30am to 1.00pm and 2.00pm to 6:30pm* * Although the practice was nominally closed between 1.00pm to 2.00pm, the doors remained open and reception staff were available to assist patients attending the practice.
Appointments available:	
Monday	8.30am – 8.00pm



Tuesday	8.30am – 8.00pm
Wednesday	7:30pm-6:30pm
Thursday	8:30pm-6:30pm
Friday	7:30pm-6:30pm

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

- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8.00pm on a Monday and Tuesday. 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 at local hubs Saturday and Sunday 8.00am until 8.00pm.
- 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.
- The practice was making efforts to improve cervical screening rates.
- It actively working with parents to improve uptake of childhood immunisations.

**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). <sup>1</sup>	Y
Patients were able to make appointments in a way which met their needs. <sup>2</sup>	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:  
 1 The practice offered a range of appointment options, including, same-day appointments for most medical needs. It also provided pre-bookable appointments, allowing patients to plan their visits ahead up to 2 weeks in advance. For appointments with the nurse staff, clinical pharmacists, and social prescriber, patients could book up to 6 weeks ahead.

Patients we spoke to during the inspection visit all expressed satisfaction with the range of appointment types available.

2 Some patients we spoke to were not happy with the arrangements for making an appointment, citing a lack of pre-bookable appointments. However, the majority of patients expressed their satisfaction with the appointments system.

The practice' performance for patient satisfaction, as measured by the GP Patient Survey, showed it was, in most areas, performing above the national average. This had been the case over a period of several years. However, patient satisfaction with appointment times had declined significantly (in 2021-22 the practice performance was above both local and national averages at 62.7% of patients satisfied with appointment times, compared to 55.2 locally and 55.0 nationally).

The practice told us it had taken into account patient feedback regarding pre-bookable and follow-up appointments and had introduced those options. It was also actively working to expand the availability of pre-bookable GP appointments. To facilitate that, the practice was in the process of recruiting another salaried GP.

Additionally, it was working on introducing an automated appointment booking system to bring added efficiency to call handling. The aim of the system was to minimise call waiting times and to book patients into available GP appointments.

**National GP Patient Survey results**

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	62.5%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	61.7%	53.4%	54.4%	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 (01/01/2023 to 30/04/2023)	45.0%	53.7%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	79.7%	68.3%	72.0%	No statistical variation

## Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	10
Number of complaints we examined.	10
Number of complaints we examined that were satisfactorily handled in a timely way.	10
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(s) of learning from complaints.

Complaint	Specific action taken
A patient complained about the appointment booking system, in particular the lack of pre-bookable appointments.	The practice investigated the complaint and explained there were a limited number of pre-bookable appointments available, but that most patients had welcomed the move to making most appointments available on the day. The practice told the patient about the changes it was planning, including offering more pre-bookable appointments.

## Well-led

## Rating: Good

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
	Y

There was a leadership development programme, including a succession plan.	Y
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### 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

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

Source	Feedback
Staff Interviews	All staff we spoke to believed there were enough staff (clinical and non-clinical) available to cover work commitments at all times, they felt supported by management and would be able to raise any concerns. They attended regular meetings and felt involved in the running of the practice.

### 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.	Y

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• Risk registers were used to maintain oversight and manage delegation of tasks and timescale for follow up.</li><li>• There was an up-to-date business continuity plan in preparation for major incidents. Staff members we spoke to displayed an understanding on how to maintain the care of patients and staff during such incidents.</li></ul>	

### 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

## 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
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

Feedback from Patient Participation Group.

Feedback
There was an active Patient Participation Group (PPG) who met regularly to discuss all aspects of practice such as recruitment, issues of concern and practice performance. They also provided recommendations for improvement including making more pre-bookable appointments available. Those expressing an opinion told us that practice met the needs of patients, but that the PPG would like to have greater involvement with the practice.

## 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. 1	Y
Learning was shared effectively and used to make improvements.	Y

### Examples of continuous learning and improvement

1 The practice had introduced remote temperature monitoring of its vaccine fridges. This increased monitoring for any abnormal temperature changes, helping to protect the stored vaccines. The software also monitored the efficiency of the vaccine fridges, and recommended actions, as needed, to maintain the fridges in working condition.

### 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 persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for those aged 25 to 49, and within 5.5 years for those aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

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

#### **Glossary of terms used in the data.**

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