

## Inspection Evidence Table

Veor Surgery

(1-549175430)

Inspection Date: 05 June 2023

Date of data download: 05/06/2023

## Overall rating: requires improvement

At this inspection we have rated the service as requires improvement. This was because the Safe, effective and well led key questions were rated as requires improvement and the responsive question was rated as good. The Caring key question was not inspected and the previous rating of good has been carried forward.

### Safe

### Rating: requires improvement

At the last inspection in 2019 we rated the practice as good for providing safe services. At this inspection we have rated the practice as requires improvement because:

- There were inconsistencies in the systems and processes to ensure infection prevention and control was managed safely.
- There was a backlog of patient records waiting for summarisation.
- Patient information stored in the electronic clinical system had not been appropriately actioned or filed.
- Medicine management procedures and systems had not been consistently followed to ensure the safety of the prescribing of medicines, stock control and security of prescriptions.
- There was an inconsistency identified in complying with safety alerts.

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes

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

Explanation of any answers and additional evidence:

- Staff were provided with detailed information and guidance within policies and procedures on how to recognise and take appropriate action when safeguarding concerns were identified.
- Clinicians were required to complete level 3 safeguarding adults and children training, although the training matrix did not evidence all GPs were up to date with this. The practice provided assurances that level 3 safeguarding training had been completed as part of the GP appraisal programme, and training had been accessed through another training provider. Following the inspection certificates of the training completed were obtained and stored within personnel folders. The safeguarding lead GP had completed additional training at a higher level with the local Integrated Care Board to ensure sufficient levels of support were accessible at the practice.
- The electronic system alerted staff to patients where safeguarding concerns had been raised or were ongoing.
- Safeguarding meetings were held in the practice. Minutes from these meetings showed specific safeguarding concerns were discussed and decisions made on the appropriate action to take. Information from the meetings were shared with relevant staff within the practice.
- Information was displayed in the care navigator's office and clinical rooms to inform staff on the action to take if they identified a safeguarding concern and included the pathway for referring patients affected by female genital mutilation (FGM).
- DBS checks were completed as part of the recruitment process. However, for one clinician there was no evidence to support the outcome of their DBS check, although the electronic system identified this had been applied for. The practice immediately addressed this and applied for another enhanced DBS check and evidence to demonstrate the completed DBS had been returned with no issues identified has since been provided to us.
- Another new member of staff in a nonclinical role had commenced work prior to their DBS check being completed. There was evidence to support that the DBS had been applied for and they did not provide direct contact to patients or had not worked alone while waiting for the check. National guidelines recommend that for staff who work without a DBS check a risk assessment should be completed. Following the inspection, we were provided with evidence which supported this DBS check had been received.

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

Explanation of any answers and additional evidence:

- We reviewed the personnel folders for 5 members of staff. The practice had carried out recruitment checks before offering a firm offer of employment. For example, checking the person's identity, obtaining references, reviewing previous employment and experience, ensuring up to date registration with a professional body if relevant and immunization/vaccination history. Prior to staff commencing work at the practice, they were provided with a contract relating to their role. Signed copies of the contracts were held on each personnel folder.
- For one out of the 5 personnel folders we reviewed there were no references stored. However, there was evidence to demonstrate these had been received at the time of appointment and had raised no issues. The manager we spoke with assured us the references would be found and stored securely in the file.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment: 17/1/23	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 14.03.23	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The fire risk assessment detailed that the fire service had inspected the premises.</li> <li>• Portable appliance testing had been carried out by an external company to ensure the equipment was safe to use. Equipment had stickers attached to show it had been appropriately tested.</li> </ul>	

### Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 01:04:23	Yes
The practice had acted on any issues identified in infection prevention and control audits.	No
The arrangements for managing waste and clinical specimens kept people safe.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff were provided with policies and procedures which provided guidance and direction on how to manage infection prevention and control (IPC) within the practice. Data sheets were maintained of all COSHH (chemicals and substances hazardous to health) materials that were available in the practice. Legionella testing of water outlets was regularly carried out. (Legionella bacteria can cause a serious type of pneumonia (lung infection) called Legionnaires' disease).</li> </ul>	

- The practice had nominated an IPC lead, although not all staff were clear who this was. IPC training was provided to all staff at a level appropriate for their role. The IPC lead had completed additional external training which was relevant to their role.
- The IPC audit carried out in April 2023 had identified some areas for improvement. For example, guidelines and policies, the general environment, consultation rooms, sluice and toilets. The cleaner's store was identified as requiring urgent action. We were unable to evidence if the action had been taken to replace missing tiles and refurbish a broken work top as the key was not available on the day of inspection. The audit did not have an associated action plan with allocated tasks or timescales for actions.
- Some areas of the practice did not promote infection prevention and control. For example, refurbishment was required in one toilet to fill in holes in the wall. In another toilet the handrail had an area of plastic covering missing and was rusty, the floor was not visually clean, and the radiator had areas of rust. This meant that effective cleaning could not be carried out to promote the control of infection.
- A hand hygiene audit had been completed two months before the inspection but staff we spoke with had not been informed of the outcome of the audit.
- The practice employed two staff members who provided cleaning each weekday. A monthly audit was completed each month to assess the cleanliness of the premises which, except for one toilet, looked visually clean. The cleaner's equipment was kept in a separate cupboard. We were unable to access this during the inspection to review equipment, COSHH materials and cleaning schedules due to the missing key.
- There were children's toys in the waiting room. Staff were unclear on who held responsibility for the cleaning of these toys. However, the practice manager and HR manager provided assurances the cleaning of the toys was carried out each day by the cleaners using antibacterial wipes and this task was reflected on the cleaning schedule. The last IPC audit carried out referenced the toys as being cleanable but no information on when they had been cleaned and who by.
- Clinical waste was stored in one of two large clinical waste bins at the rear of the practice. On the day of inspection only one of these bins was locked. We were provided with assurances that this would be dealt with immediately and a reminder provided to staff.

**Risks to patients**

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

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

- Staff provided cover for colleagues during holiday periods and when short notice sick leave occurred. There had been periods of time when staff felt under pressure due to the insufficient numbers of staff on duty. We saw minutes of team meetings which demonstrated this had been raised and support offered in the short term while recruitment was ongoing.
- Staff had been provided with guidance to provide support in roles other than their own and told us that managers would also provide support and cover during busy times.
- The practice had secured additional nursing hours from a nurse working within the primary care network (PCN), one day a week, to support with the provision of diabetic care and review for patients.
- The practice had recently recruited a salaried GP who was to provide 6 clinics per week and was in the process of recruiting another GP. Vacancies in the care navigation team were being advertised at the time of the inspection.
- A nurse practitioner employed by the practice worked remotely, contacting patients by telephone to enable online consultations.
- Staff received training to provide care and treatment to patients in an emergency and to recognise a deteriorating patient. For example, if a patient arrived with chest pain, or a child with a head injury, they would immediately alert a clinician and the patient would receive immediate attention.
- The care navigators were supported by a GP or other clinician to provide patients with appropriate guidance or care pathways.

**Information to deliver safe care and treatment.**

**Staff did not always have 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	Yes
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.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results, and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice employed a part time member of staff for the summarisation of patient records which were received into the practice in paper format. (Summarising is the process of taking a set of patient's notes and extracting an accurate medical history in chronological order). However, the member of staff also had other tasks to fulfill within their working hours. This had meant a backlog in the summarisation of patient records. It was unclear how many records were waiting for summarisation. The practice were not able to provide this information for us at the time of the inspection. However, following the inspection we were advised there were 149 sets of records awaiting summarisation. The records were stored in boxes which identified the month they had arrived in the practice. At the time of inspection, the records received in May 2022 were being summarised as the ones waiting the longest and so were addressed</li> </ul>	

first. There was no system to prioritise the records of vulnerable patients with complex needs. Since the inspection we were informed that work was ongoing to catalogue the records identifying those records which were higher in priority. There was a risk that important information would not be known or available to clinicians providing care and treatment to patients. The practice had identified the risk to patients and were considering contracting an external organisation to summarise the records. However, there was no formal plan or timescales in place for this to be actioned.

- The practice had a referrals policy and procedure. Administration staff provided support to clinicians to ensure referrals to specialist services were sent promptly. Referrals for patients who were referred to specialist services urgently, for example under the 2 week wait system, were completed by the clinician who was referring the patient. The administration staff completed weekly audits to ensure the referrals had been sent, received by secondary care and actioned. This reduced the risk of a referral being 'lost' in the system.
- The electronic system used by the practice enabled information to be shared to individual members of staff to action. These were known as 'tasks'. Our clinical searches found there were test results waiting in the task system which did not appear to have been reviewed and/or actioned or filed. The practice agreed to review the tasks to ensure there was no patient information which required prioritising and actioning. We reviewed the tasks waiting for action on the day of the inspection. We saw the oldest task was from the 3rd of May 2023. This was a task to arrange a patient appointment for the coming week. This had been completed but the patient had not been contacted. The second oldest task was five days old from the 1st of June 2023 from a patient wanting to speak to a doctor. The care coordinator had attempted to contact that patient on the day of inspection.
- We saw minutes of meetings which demonstrated practical training had been delivered to staff on the management and actioning of tasks.

### Appropriate and safe use of medicines

**The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, these were not consistently followed.**

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)	0.91	0.88	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)	9.0%	8.5%	8.1%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) (NHSBSA)	4.90	5.28	5.24	No statistical variation



Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	189.3‰	154.3‰	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) <small>(NHSBSA)</small>	0.77	0.61	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	9.9‰	7.0‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	No
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	N/A
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence, including from clinical searches.

- Data showed that the total number of prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) at the practice was higher than the local and national averages. (These are medicines used for the treatment of epilepsy and nerve pain and in some cases anxiety). The clinical search identified 214 patients who were prescribed pregabalin and gabapentin. This was discussed during feedback to the practice with the GP specialist adviser who completed the searches and acknowledged that the patient demographics would potentially result in this higher prescribing. The practice provided additional information on the work ongoing to review patients prescribed these medicines.
- Data showed that the number of patients prescribed multiple psychotropic drugs per 1,000 patients (01/07/2022 to 31/12/2022) at the practice was higher than the local and national averages. These drugs have an effect on psychological function. This was discussed during feedback to the practice with the GP specialist adviser who completed the searches and acknowledged that the patient demographics would potentially result in this higher prescribing. The practice provided additional information on the work ongoing to review patients prescribed these medicines.
- Following the remote clinical searches, we asked the practice how they audit the prescribing of non-medical prescribers. (Clinicians who are not doctors). We were told there had not been any formal auditing processes carried out. During the onsite inspection the practice informed us that a formal auditing process had been commenced and provided written documentation which demonstrated the start of these audits. The initial findings showed the prescribing carried out had been accurate and appropriate. Guidelines had been developed for non-medical prescribers to follow which identified medicines they could prescribe, dosages and duration of prescription.
- Prescription pads were monitored by the reception staff. We followed the process with the lead receptionist who demonstrated that each room had a separate envelope with prescriptions allocated for use. The reception staff allocated the prescriptions to the rooms in use that day. At the end of the day the reception staff gathered the blank prescriptions back in and recorded their use. However, we observed that blank prescriptions were not held securely at all times. For example, we saw prescription paper in printer drawers which were not secured.
- Medicines were stored in the theatre suite, the theatre was not in use but locked at the time of the inspection. We observed there were a large number of ampoules of local anaesthetic for the use during minor surgery. However, there was no record to identify stock received or when the medicine was used, which would not enable a system to identify if any medicines were missing.
- The staff had access to emergency equipment and medicines which were stored on a trolley in the clinical area. The equipment was checked weekly, and the staff member signed a log to demonstrate the check had been carried out. However, there was no list of what equipment was stored on the trolley and therefore there would be no means to identify if anything was missing.
- The emergency medicines were stored in a grab bag on top of the trolley so that staff would be able to quickly respond to an emergency. However, there was no list of medicines held on the trolley so therefore there would be no means to identify if anything was missing.
- Audits had been carried which had identified antibiotic prescribing was appropriate and within guidelines.

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

**The practice learned and made improvements when things went wrong/did not have a system to learn and make improvements when things went wrong.**

**Significant events**

**Y/N/Partial**



The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	13
Number of events that required action:	13
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice recorded significant events and staff we spoke with were aware of how to raise concerns.</li> <li>The significant events log did not clearly identify who was responsible for any associated investigation or the actions taken to address the risk. However, we saw meeting minutes which clearly identified discussions of significant events and the shared learning that had arisen from the significant event.</li> </ul>	

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

Event	Specific action taken
A patient had been prescribed a medicine which due to their age conflicted with a safety alert.	The practice took immediate action to provide care and treatment to the patient. Action had been taken to review patients prescribed this medicine and shared learning with clinicians.
The laboratory had telephoned with a result regarding a patient test. The staff member who took the message misheard and recorded the result incorrectly. This meant that the follow up review required was delayed. There was no harm to the patient.	The significant event record did not include any investigation or reference to discussion or include learning outcomes. There was no record that the actions indicated had been completed or discussed with the wider staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice pharmacist carried out searches to ensure the practice kept up to date with safety alerts. Staff confirmed they were provided with emails regarding safety alerts.</li> <li>We saw that there were four patients aged over 65 who were on doses of an antidepressant which conflicted with a MHRA alert. The practice had recorded the risk had been discussed with the patient. However, the records did not specify the actual risk to individual patients and that the patient, following discussion, was able to give informed consent to accept the risk. The practice had previously raised a significant event relating to the prescribing of this medicine, they had reviewed all patients prescribed this medicine and had shared learning with clinicians to ensure all were aware of this MHRA alert.</li> </ul>	

## Effective

## Rating: Requires improvement

At the last inspection in 2019 we rated the practice as good for providing effective services. However, at this inspection the rating has changed to requires improvement because:

- Monitoring processes, and oversight of systems and processes, had not been carried out appropriately to ensure patients were in receipt of effective correct care and treatment with the medicines prescribed to them or for their long term conditions. However, the practice had taken immediate action following the inspection to address these issues.
- The provision of childhood immunisations did not meet national targets.
- The provision of cervical screening for eligible women did not meet national targets. Not all processes for supporting staff were formalised and recorded.

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

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence:	

- The practice employed an urgent care practitioner. They carried out home visits to vulnerable and housebound patients including those living in care homes. As part of providing care and treatment in care homes, virtual and on site 'ward' rounds were carried out in care homes to support the patients' ongoing health needs. Prior to the inspection, we were provided with positive feedback from a care home regarding the support, care and attention provided by the practice to residents.

## Effective care for the practice population

### Findings

- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. We were told by the practice that health assessments were provided on a recall process, based on the patients' birthday month. However, not all staff understood how the recalls took place. For example, one nurse thought the patient was required to request a health check. There was a poster in the waiting room which advised patients to speak to reception staff if they required a health assessment.
- All patients with a learning disability were offered an annual health check.
- As part of the primary care network the practice had access to a care coordinator one day a week who provided support to patients who had received a cancer diagnosis.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. The social prescriber provided support and information to patients at the end of life. For example, by providing information on external organisations who could provide support and assistance.
- The social prescriber was aware of housebound patients registered with the practice and provided a link between the patient and practice.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. The practice employed the services of an external organisation to provide non clinical support and provide guidance and information to people who misused substances. A meeting was held within the practice, led by the external organisation. The registered manager explained that when any drug and alcohol issues were identified these patients were referred to the organisation who managed aspects of drug and rehabilitation, including housing and benefits.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The primary care network had recently recruited a mental health worker who would provide additional support to the practice when they had started work.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- Our clinical searches identified 20 patients with blood tests indicating they may have undiagnosed diabetes which had not been identified or recorded in their records, so were not always reviewed in line with national guidance. This review would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. The practice provided additional information at the site visit and informed us that the patients identified at risk during the remote clinical searches had been reviewed and contacted where necessary.
- 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. For example, the clinical searches identified that the practice had 635 patients registered with asthma and 25 of those patients had been prescribed 2 or more courses of rescue steroids in the past 12 months. Rescue steroids describe a course of steroid treatment to treat an acute episode of asthma related ill health. We reviewed the records for 6 of these patients. We saw that improvement was needed in recording details of clinical observations at face to face appointments or questions asked to determine how the patient was during telephone conversations. There was no evidence that safety netting advice had been provided for these patients. (Safety-netting advice is information shared with a patient or their carer designed to help them identify the need to seek further medical help if their condition fails to improve, changes, or if they have concerns about their health). Three patients had more than two courses of rescue steroids in the past 12 months and either had not been provided with a steroid treatment card or their records had not been coded to demonstrate this had happened. However, routine asthma reviews we looked at were completed in detail.
- The clinical searches identified that 5 patients out of 395 diagnosed with hypothyroidism had not had appropriate monitoring. For these patients we saw that they had attended the practice for blood tests which had not included a thyroid function test, which suggested that the electronic system alerts were not recognised or responded to. Medication reviews for these patients did not provide full details regarding their medicines to treat hypothyroidism.
- The records for 2 patients out of 38 prescribed a medicine used to treat inflammatory conditions, including rheumatoid arthritis had not been completed in full. The records did not specify the day of administration of the medicine, which does not comply with national guidance and the reason for the prescription of the medicine was not specified. We noted that one patient was prescribed a higher dose of the medicine that the most recent hospital letter suggests. This was raised with the practice who reviewed the patient records and provided explanations.
- We reviewed the records of 2 out of 4 patients who were prescribed a medicine to stabilise mood. The electronic system had not alerted the practice that monitoring for this medicine was overdue. Therefore, reminders had not been sent in a timely way to patients to maintain monitoring intervals to ensure the correct dosage had been prescribed. The practice provided assurances during the inspection that this had been addressed.
- Patients with long-term conditions were generally offered an effective annual review to check their health needs relating to their long term condition 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. For example, additional support and training had been provided to newly recruited staff so they could effectively complete diabetes and COPD patient reviews.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension although as reported earlier these patients were not always followed up in a timely way. The practice was involved in a diabetes and COPD recovery programme within their PCN with the aim to prevent type 2 diabetes and supporting the delivery of high-quality care for people living with all forms of diabetes.

- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

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)	51	57	89.5%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	53	60	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)	52	60	86.7%	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)	52	60	86.7%	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)	88	100	88.0%	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 advised that there had been difficulties encouraging parents and carers to bring their children for vaccinations. However, the practice told us there had been a workflow ongoing which meant there were more children vaccinated than in the above data.
- The practice reviewed the immunisation data collated each week to review progress in meeting the national target. Text messages/letters were sent to remind parents/guardians to book their children in for the required immunisations. If no contact had been received after 2 contacts the nursing team followed up with a telephone call to the parents/guardians to discuss/encourage them to make an appointment.
- The practice provided their most up to date data to us following the inspection which showed 90% of immunisations had been delivered. However, this was unverified data at the time of the inspection.

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)	54.7%	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)	66.6%	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). (31/12/2022 to 31/12/2022) (UKHSA)	62.4%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	48.1%	55.2%	54.9%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The practice advised that there had been difficulties encouraging women to attend the practice for cervical screening.</li> <li>The practice reviewed the cervical screening data collated each week to review progress in meeting the national target. Text messages/letters were sent to remind women to book an appointment for the procedure. If the practice had received no response an initial 2 contacts the nursing team telephoned the patient to discuss the procedure and encourage them to make an appointment.</li> <li>The practice offered early morning and evening appointments and some Saturday appointments to suit patients who were working or unable to attend during the week.</li> <li>The practice did not identify that patients had declined the appointment following 3 reminders as they believed it would be appropriate for patients to receive further reminders. However, the practice informed us this did impact their performance figures against the national target.</li> <li>The practice was provided with support from the PCN Cancer Care Co-ordinator who attended the surgery each week to review patients diagnosed with cancer. A recent meeting within the PCN agreed the Lead GP or cancer services will work with the practice team to co-ordinate services for patients diagnosed with cancer.</li> </ul>

### Monitoring care and treatment

The practice had a 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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> <li>The practice had audited the prescribing of hormone replacement therapy following new regulations introduced in April 2023. The audit identified which patients required a separate prescription for their hormone replacement therapy to ensure they received their medicines in a timely way. The electronic prescribing system was updated, and learning shared with staff at a team meeting.</li> </ul>	

<b>Any additional evidence or comments</b>	
<ul style="list-style-type: none"> <li>The practice held a monthly learning and audit meeting. This meeting provided a forum to identify any audits which were required, review those ongoing and share learning from completed audits.</li> </ul>	

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	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.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>New staff were provided with a role specific induction programme. This covered the main aspects of their role and identified the date the training had been completed together with the staff member and trainer's signatures. Completed induction forms were held on staff personnel folders.</li> <li>Staff found their team leaders and senior management approachable and helpful. There were informal systems of one to ones and clinical supervision was arranged by the clinicians themselves. However, not all these processes were recorded.</li> </ul>	

### Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• There was a clinical meeting each day. This was an informal get together of clinicians working in the practice on the day. Staff told us they had the opportunity to discuss any issues they had identified and discuss patient care with their colleagues in this supportive forum.</li> <li>• The practice worked with their internal and external colleagues well. This meant information was shared between teams and clinicians to ensure patients to enable the appropriate care and treatment was provided.</li> </ul>	

### Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice employed a social care prescriber and an external consultant who provided support and guidance to patients regarding living healthier lives. However, we received information that one person felt they had been treated differently as a result of their lifestyle health choices.</li> <li>• Prior to the pandemic the practice had provided a café area in the waiting room to enable patients to drop in, socialise and attend specific self-help groups.</li> <li>• The practice had been part of a programme with NHS England looking at health in relation to benefits. The practice provided patients with an opportunity to attend a weekly group which provided support with the cost of living crisis.</li> </ul>	

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**Consent to care and treatment**

**The practice 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.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient’s mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Yes
Explanation of any answers and additional evidence, including from clinical searches: <ul style="list-style-type: none"><li>• We carried out a review of the clinical records for four patients. We saw that for all four patients a DNACPR had been recorded and identified the patients’ views had been sought and respected.</li><li>• The clinicians completed a mental capacity assessment as part of the care plan assessments to support the use of DNACPR forms in use.</li><li>• However, the clinical records did not consistently show that consent had been obtained prior to all examination or treatment. However, clinicians stated they discussed this with each patient.</li></ul>	

**Caring**

**Rating: Good**

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as Good.

**Responsive**

**Rating: Good**

We identified at this inspection that while complaints were investigated and action taken, there had not been an audit process completed to identify and address any themes or trends.

## Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice worked with a local charity and provided parking and charging facilities for the charity's electric car on site. The charity provided a transport service for older and/or vulnerable patients to access the practice. This improved accessibility to services and reduced the need for home visits to be made by the practice.</li> <li>The practice offered support and practical advice to patients, including vulnerable patients and those who had caring responsibilities. There was a café located within the practice together with support groups patients could drop into. For example, a social coffee morning and an art and craft group was held weekly. A fibromyalgia support group was held each month. This provided a space for patients to discuss the effects of fibromyalgia on their lives and share experiences. A monthly book club was held in conjunction with a visiting library.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8 am – 6.30 pm
Tuesday	8 am – 6.30 pm
Wednesday	8 am – 6.30 pm
Thursday	8 am – 6.30 pm
Friday	8 am – 6.30 pm
Appointments available:	
Monday	8 am – 6 pm
Tuesday	8 am – 6 pm
Wednesday	8 am – 6 pm

Thursday	8 am – 6 pm
Friday	8 am – 6 pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>• Patients had a named GP who supported them in whatever setting they lived.</li> <li>• 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.</li> <li>• The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.</li> <li>• Parents or guardians calling with concerns about a child were offered a same day appointment when necessary. This was confirmed by patients we spoke with during the inspection.</li> <li>• The practice confirmed that people who were homeless were provided with care and treatment from a homeless health service in the local area.</li> <li>• People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as Travelers. The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.</li> <li>• The practice had access to a social prescriber for 5 days each week who supported vulnerable patients.</li> <li>• Interpretation services were available for patients who did not have English as a first language.</li> </ul>

**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.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had implemented an online triage and patient flow system. (The electronic system supported patient triage and flow management with an aim to improve patient access and release GP capacity). This meant patients could request advice and access to appointments with clinicians by completing an online form. The system was monitored by a duty GP to triage patients appropriately. On occasions when it had not been possible to fulfill the duty GP position, an urgent care practitioner had provided triage for patients completing the online forms. On rare occasions when there was not anyone</li> </ul>	

to perform this role the online system had been turned off to ensure patient requests were not missed. On these occasions patients were required to telephone the practice.

- On the day of inspection there were two GPs and an urgent care practitioner available to patients. Another GP was providing a triage role by reviewing all online request forms.
- All morning appointments, including telephone appointments, had been filled by 11am. The practice had a system that appointments could be booked at certain time periods. There were 15 appointments available in the afternoon. These were embargoed until 2pm. There were appointments available for the next day which were not able to be booked until that morning. This meant that appointments remained available for patients who were triaged as a priority.
- There were nurse led clinics held each day and reception staff added patients to the clinic lists.
- We spoke with one patient during the inspection who told us that appointments for babies and children were available immediately but for adults these were less accessible.
- Another patient told us that it was not easy to be able to book an appointment with a named doctor which did not provide continuity for their care. They acknowledged that this might be different if the online system for contacting the practice could be used but this was difficult for them.
- The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (during the timeframe of 1 January 2022 to 30 April 2022) was 79.5% which was higher than the local (78.6%) and national average (72.4%) recorded.

### 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)	43.6%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	57.0%	63.8%	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)	65.1%	62.1%	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)	74.1%	78.0%	71.9%	No statistical variation



### Any additional evidence or comments

- The practice had introduced an electronic system, overseen by a clinician, for patients to receive medical care and treatment. Staff considered this had helped improve access by telephone for patients who could not use the online system.

Source	Feedback
Concerns raised to CQC	Concerns had been raised to Care Quality Commission regarding access to the practice, management of the service and staffing levels.

### Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care/  
Complaints were not used to improve the quality of care.**

Complaints	
Number of complaints received since January 2022.	18
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

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

Example(s) of learning from complaints.

Complaint	Specific action taken
A family had complained about how a doctor had made them feel during a consultation.	An apology was provided by the practice to the family. However, there was no record of any investigation or discussion as part of a meeting. There was no statement or information retained from the clinician involved and no evidence of any learning shared with staff.
A patient had complained about the attitude of a clinician during a consultation.	The practice had commenced an investigation and responded to the patient. However, this was ongoing at the time of our inspection.

- A complaints register was maintained and there was oversight of this register by a care coordinator lead.
- Complaints were signposted to the care coordinator lead who provided an initial response to the patient or complainant which advised of any investigation that was to take place into the issues raised.
- The lead care coordinator had completed online training regarding responding to complaints. If it was felt that a complaint was complex support was sought from the business manager.
- No audits had taken place to identify and address any themes or trends.

## Well-led

## Rating: Requires Improvement

At the last inspection in 2019 we rated the practice as good for providing well led services. However, at this inspection the rating has changed to requires improvement because:

- Oversight of systems and processes was not consistent and structures, processes and systems to support good governance and management were not consistently or clearly set out.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Staff confirmed that managers were supportive and available within the practice. There was no practice manager in post at the time of the inspection. The business manager and human resources manager (HR) provided the role across the week and staff were aware of which days of the week each worked.</li><li>• Managers were supported to develop their knowledge and skills within their roles and staff who expressed an interest in developing the management skills were supported to access training. For example, one member of staff had been promoted into a new managerial role and the practice had contacted the local integrated care board for support in accessing training and coaching to support them in their new role.</li><li>• The practice recognised the challenges they faced and had taken steps to address issues. For example, recruitment of GPs had been challenging given the geographical location of the practice. Consideration was being given to salaried GPs becoming partners.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial

Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The vision and values in place at the time of the inspection had included views from the patients and staff when initially developed. The practice had reviewed the vision and values, discussed with the staff and agreed development was needed. However, this had happened prior to the pandemic and had been put on hold throughout the pandemic.</li> <li>The linked strategy was being reviewed at the time of the inspection to reflect the wider health and social care system. A team away day was being planned to discuss the vision and strategy with the staff and to obtain their input and views. However, there had not been a date set for this at the time of the inspection.</li> </ul>	

## Culture

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

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

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

Source	Feedback
Staff working in the practice	Staff were positive about working at the practice, felt supported and valued. They made positive comments about the team working at the practice.

## Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No

Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Oversight of systems and processes was not consistent. Structures, processes and systems to support good governance and management were not consistently or clearly set out.</li> <li>• For example, the system to summarise patient records had not been effective and there was a backlog of records to be summarised.</li> <li>• Auditing and monitoring of the service had taken place but there were not clear records to demonstrate the action taken as a result of the audits. For example, following the IPC audit completed in April 2023 it was unclear if actions identified had been addressed.</li> <li>• The management of complaints did not provide oversight to identify themes and trends of complaints. This meant the practice did not gather information to reduce the likelihood of complaints regarding the same issues occurring again.</li> <li>• There was a lack of oversight in the systems and processes to ensure infection prevention and control was managed safely.</li> <li>• There had not been oversight or management of patient information stored in the electronic system, identified as tasks, to ensure this information had been appropriately actioned or filed.</li> <li>• There had been a lack of oversight of medicine management to ensure the safety of the prescribing of medicines, stock control and security of prescriptions.</li> </ul>	

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice could not demonstrate that recruitment procedures had been consistently followed at the time of the inspection. This was because personnel records did not include all information that had been gathered during recruitment of staff to demonstrate staff were suitable for their roles. However, the practice responded immediately and provided additional evidence following the inspection to provide assurances this had been addressed.</li> <li>• There had been a lack of oversight to manage the risks from outstanding 'tasks' allocated to staff members. This meant important information may not have been processed and actioned to ensure patient safety.</li> </ul>	

- The system to ensure safe management of medicines had not been monitored to reduce risk. For example, the practice was not able to demonstrate the security of blank prescriptions or the stock control of all medicines. This meant there was a risk of prescriptions or medicines being used inappropriately without the practice having an awareness.
- There had been inconsistencies in the monitoring and oversight of patients on high risk medicines and the provision of care and treatment for patients with long term conditions.
- Front reception staff had not received any training in managing challenging behaviour. They confirmed they had not felt physically intimidated but were sometimes verbally abused.
- The practice had close circuit TV cameras (CCTV) installed. There was signage in reception to alert visitors to the CCTV, but this was not easily visible. We discussed this with the practice and were provided with assurances that clearer signage would be put in place.
- The building was opened in the mornings using a keypad. There was not a clear system for changing / updating of the door codes. The security policy dated December 2022 stated the door code would be changed every six months and a risk assessment dated December 2022 stated it would be changed annually. The first member of staff to arrive would open the building which meant they were lone working at this time. This meant there was a risk to individual members of staff.
- Staff who drove the vehicle for bringing patients to the clinic were required to produce the appropriate documentation to demonstrate they were legally able to drive the vehicle.
- Fire prevention equipment was checked regularly, and records maintained to detail when the check took place and who by. Any remedial action taken to maintain equipment was detailed on the checks.
- The practice had developed a major incident plan which was shared with staff to ensure the continuity of the service in the event of a major incident.

#### 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.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• We were told the telephone system could identify calls waiting but not identify abandoned calls. There was no clear guidance regarding this, or action taken to audit waiting calls and/or abandoned calls which would help the practice to monitor their performance.</li> </ul>	

#### Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes

Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Callers to the practice were advised that all calls would be recorded for training and monitoring purposes.</li> </ul>	

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice team all met together at the start of each day. This provided a forum for staff to raise any issues, updates to be provided and generally check in on each of the team.</li> <li>• The practice had completed a patient access survey within the PCN. The report and audit was being processed at the time of the inspection. However, the national GP survey showed positive outcomes for patients.</li> </ul>	

Feedback from Patient Participation Group.

Feedback
Patient Participation Groups (PPGs) are made up of volunteers interested in healthcare issues which meet to decide ways and means of making a positive contribution to the services and facilities offered by the surgery to patients. <ul style="list-style-type: none"> <li>• We spoke with a member of the PPG who told us they could raise any issues with the practice and felt they were listened to. Examples of changes made following concerns raised by patients included resurfacing of the car park and action to address the telephone system.</li> </ul>



- The PPG was involved with the provision of volunteers to run the café on a weekly basis and the development of groups, such as walking, gardening, arts and crafts and writing, for patients to attend. At the time of the inspection the PPG and the practice were encouraging more people to join the PPG.

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	

### Examples of continuous learning and improvement

- The practice employed an external consultant to provide support for people with addictions. They provided a weekly clinic to which anyone was welcome to attend for support, information or referral to other clinicians. The practice and the consultant had recognised a need to start a drop in clinic/group for patients addicted to prescription medicines. We reviewed the business plan for this service and saw that one of the GPs had opted to be a named contact to support the process and clinic when it commenced.
- Staff were encouraged to identify external training sessions relevant to their role and were supported to attend these with financial support and time allowed from the rotas.
- The practice worked with an external organisation to share a vehicle and bring patients to the practice who would otherwise be unable to attend appointments and meetings.

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of 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.