

# Care Quality Commission

## Inspection Evidence Table

### Ambar Medical Centre (1-2744921273)

Inspection date: 29 September 2022

Date of data download: 04 August 2022

## Overall rating: Good

### Safe

Rating: Good

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice had a named safeguarding lead and administrative support for managing safeguarding concerns.</li><li>Staff we spoke with were aware of the safeguarding processes in place and had access to safeguarding policies and procedures for support.</li><li>We reviewed a sample of training records to check that staff were up to date with their safeguarding training for children and vulnerable adults and found the practice was not able to evidence that all clinical staff were up to date with safeguarding level to the required level. Following the issuing of the draft report the training had been completed and forwarded to us.</li><li>We saw from the minutes of meetings reviewed that safeguarding was regularly discussed at the practice, meeting notes were detailed with any actions or follow up recorded. Staff told us</li></ul>	

Safeguarding	Y/N/Partial
<p>that they contacted the health visiting teams directly when they needed to discuss anything as they were not usually able to attend these meetings.</p> <ul style="list-style-type: none"> <li>At the time of inspection, the practice was training to become an IRIS (Identification and Referral to Improve Safety) practice so that it could be better placed to support patients at risk of harm from domestic violence.</li> <li>The practice had an understanding of Female Genital Mutilation (FGM) and the reporting requirements but advised this was not a significant issue within their practice population.</li> <li>The practice told us that all staff working at the practice received a DBS check, and a review of a sample of four staff records confirmed DBS checks were in place for these staff and a risk assessment had been completed for a non-clinical member of the team.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We reviewed recruitment records for two recently employed staff and found appropriate staff checks in place.</li> <li>We reviewed staff immunisation records for four members of staff (clinical and non-clinical) and found records had been maintained.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 15 June 2022	Yes
There was a fire procedure. Date of fire risk assessment: 18 November 2020	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 practice had Health and Safety Policies and procedures in place and had undertaken a Health and Safety Risk Assessment within the last 12 months.</li> <li>The practice shared with us documents to demonstrate fire systems in place were regularly serviced and maintained.</li> <li>The practice had undertaken a recent fire drill to ensure staff knew what to do in the event of a fire.</li> <li>The maintenance, calibration and electrical safety checks of clinical equipment and portable appliances had been carried out to ensure they were safe to use. We noticed that the latest calibration checks were slightly overdue. However, during the inspection process the practice sent us evidence that this was now up to date.</li> </ul>	

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## Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: July 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>During our onsite visit to the practice we found the premises visibly clean and tidy. Cleaning was part of the contractual arrangements with the landlord. Staff told us they could speak directly with the cleaners or cleaning company if they had any concerns.</li> <li>The practice had a named infection prevention and control (IPC) lead and an infection prevention and control policy in place to support staff.</li> <li>Records seen showed that staff received and were up to date with IPC training.</li> <li>An IPC audit had recently been undertaken and staff were able to tell us about some of the actions taken in response to the audit for example, removing items from the storeroom floor and discussions with the cleaning company to ensure they met required standards.</li> <li>Reception staff were able to describe the systems for safely handling clinical specimens.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>A staff rota was in place to ensure enough staff were on duty to meet the needs of the service.</li> </ul>	

- The provider had a second practice close to Ambar Medical Centre, staff were able to work between the two sites to provide cover when needed.
- Staff told us that they would also work flexibly to cover periods of absence and there were limits on the number of staff that could take leave at any one time. Reception and administrative staff were trained across a range of duties so that they could help when needed.
- There was a locum pack which contained useful information about the practice for staff working there on a temporary basis.
- Staff had access to emergency medicines and equipment in the event of a medical emergency and knew where to find them when needed.
- Basic life support and sepsis training were part of the practice's mandatory training requirements. A sample of training records reviewed showed that most staff had received basic life support training (BLS). However, there was no evidence provided at the time of the inspection that this had been completed by one of the clinical staff, the practice subsequently forwarded evidence to us following the issuing of the draft report. Inhouse training had been arranged on the day of our site visit.

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Our review of the clinical system and records found information was recorded appropriately to support the safe care and treatment and test results were reviewed by doctors in a timely way.</li><li>• The practice had a system for monitoring two week wait cancer referrals to check that the patient received an appointment and was seen.</li></ul>	

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.58	0.81	0.79	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	4.3%	6.2%	8.8%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	4.95	5.21	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	121.7‰	138.1‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.85	0.66	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	11.1‰	8.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• As part of our inspection we looked at the management of medicines through clinical searches and reviews of a sample of patient records. We found the practice was managing patients medicines safely. For example: <ul style="list-style-type: none"> <li>○ We looked at patients on three Disease-modifying antirheumatic drugs (DMARDs) which have the potential for serious side effects and found all were receiving the required monitoring and blood tests. DMARDs are commonly used to treat inflammatory conditions.</li> <li>○ We reviewed patients on two high risk medicines used to treat heart conditions and high blood pressure. These medicines also require regular monitoring due to the risk of side effects. We found most patients on these medicines had received the required monitoring and low numbers who had not. Records showed that the practice had tried to contact the patients whose monitoring was overdue but the patients had not responded.</li> </ul> </li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>• National prescribing data showed practice prescribing was in line with other practices locally and nationally. The data showed that the practice was performing well in relation to reducing antibiotic prescribing.</li> <li>• The practice had carried out medicines audits to ensure prescribing in the areas reviewed was in line with evidence-based practice.</li> <li>• During our onsite visit to the practice we saw that there were systems in place to ensure the safe management of prescription stationery, emergency medicines and vaccinations to ensure they were fit for use, when needed.</li> <li>• The practice employed four non-medical independent prescribers (two pharmacists and two nurses). The GP carried out a review on a sample of prescribing activity for all prescribers on a monthly basis and shared findings with them to support learning and improvement.</li> </ul>	



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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months: 2022/23	7
Number of events that required action:	7
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff we spoke with knew how to report incidents and significant events and were able to share examples of learning from them.</li> <li>We saw from the minutes of practice meetings that incidents were a standing agenda item and had been discussed with staff to support learning and improvement.</li> </ul>	

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

Event	Specific action taken
A sample was not correctly labelled and was subsequently rejected by the hospital laboratory.	The incident was reviewed and learning shared with staff to check samples before sending.
Patient information had been scanned and filed in the wrong clinical records.	The incident was reviewed and learning shared with staff to be more vigilant when scanning and filing records.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice pharmacist took the lead on managing and acting on safety alerts such as those from the Medicines and Healthcare products Regulatory Agency (MHRA). Relevant safety alerts were discussed at practice meetings to raise awareness among staff.</li> <li>As part of our inspection we reviewed action taken by the practice in response to two MHRA alerts.               <ul style="list-style-type: none"> <li>The first MHRA alert we looked at related to a medicine that should not be given at a high dose to patients over 65 years due to the potential risk of abnormal heart rhythm. Our clinical searches found two patients over 65 years receiving a high dose of this</li> </ul> </li> </ul>	

medicine. In both cases the patients had only recently turned 65 years and had yet to receive their annual medicine review since becoming 65.

- The second MHRA alert we looked at was a medicine that can have an adverse impact on the development of unborn babies if taken during pregnancy. We reviewed a sample of five patients of childbearing age issued this medicine and found appropriate discussions of the risks had taken place in all except one patient, which we alerted the practice to.

## 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Clinical staff we spoke with were able to describe how they kept up to date with evidence-based practice.</li><li>• Clinical issues were regularly discussed between members of the team at practice meetings for example, reviews of recent deaths.</li><li>• Our clinical searches found patient's care and treatment was regularly reviewed and monitored for example, in relation to high risk medicines and long term conditions.</li></ul>	

## Effective care for the practice population

### Findings

- The practice identified older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs and were supported by the community health teams.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- 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.
- 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 demonstrated that they had a system to identify people who misused substances and referred or signposted them to appropriate services for their needs.
- 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

- As part of our inspection we reviewed the records of a sample of patients with various long-term conditions and/or the potential for developing a long-term condition and found patients were generally well managed. For example:

We reviewed the records for five patients with potentially poorly controlled asthma that had been issued two or more rescue steroids in the last 12 months. We found that all five patients received appropriate follow up at the time the steroids had been issued and had received annual reviews of their asthma. Two of the patients met the criteria for a steroid card however records showed that only one patient had been given one.

We identified patients with late stage chronic kidney disease (CKD) who required follow up of renal monitoring and found that one patient was overdue a follow up.

We identified three out of 72 patients with hypothyroidism who had not had monitoring in the last 18 months. We reviewed the three records and found all three patients had recently been contacted to attend for monitoring, however, recall to attend had not been consistently implemented since the patient had become overdue.

We reviewed the records of five patients with potentially poorly controlled diabetes, we found that these patients were being appropriately followed up.

Our clinical searches found no patients with a potential missed diabetes diagnosis based on their diabetic blood test readings.

We identified four patients with potentially missed diagnosis of chronic kidney disease. We reviewed the clinical records for the four patients and found although no harm was identified, the patients needed follow up monitoring at the appropriate repeat intervals to support a CKD diagnosis.

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. The practice had an established schedule for recalling patients with long term conditions to be seen.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were asked to complete home blood pressure monitoring and were given a diary to complete to share results with the practice. Staff told us that patients who did not have a BP monitor were asked to return to the practice for further readings.
- Patients with COPD were offered rescue packs, where appropriate.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	29	31	93.5%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	30	31	96.8%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for	30	31	96.8%	Met 95% WHO based target

Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	30	31	96.8%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	33	37	89.2%	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

- Data showed positive trends over time for the uptake of child immunisation in most of the indicators reviewed.
- We saw that the practice was meeting both the minimum uptake target of 90% and the World Health Organisation (WHO) target of 95% (the recommended standard for achieving herd immunity) for the uptake of childhood immunisation between April 2020 and March 2021 in most indicators. The only exception was the immunisations given to children aged 5 which was just below the 90% minimum uptake target.
- Staff we spoke with told us that it had been a challenge within the practice population to get patients to attend for child immunisations but that they had persevered with identifying and contacting non-attenders and worked with the health visitors where necessary.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	70.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	27.4%	55.7%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	30.7%	57.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	0.0%	50.3%	55.4%	No statistical variation

#### Any additional evidence or comments

- The practice was below the national target of 80% for the uptake of cervical cancer screening. Staff told us about the systems in place for recalling patients to attend. The practice told us that they had also been given additional nurse support from public health to increase the uptake of cervical screening.
- Data trends showed that the uptake for cervical screening was improving.
- The practice nurse told us that they maintained records of cervical screening samples taken which they used to check that results had been received back from the laboratory.
- Uptake of breast and bowel screening was significantly below local and national targets. An alert on the clinical system told staff when patients had not returned their bowel cancer screening kit so that they could opportunistically remind them.

## Monitoring care and treatment

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

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

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

- The practice had established effective systems for identifying and recalling patients that needed follow up and reviews for their long term conditions and high risk medicines. This was evidenced through our clinical searches.
- The practice shared with us two medicines audits that they had recently undertaken. This included:
  - An audit of Methotrexate to check adherence to a safety alert which stated the day of the week the medicine should be taken should be recorded to minimise the risk of overdose. (Methotrexate is a disease-modifying antirheumatic drug that has the potential for toxicity if not taken correctly). The first audit undertaken in June 2022 found none of the four patients identified had the day of the week to take the medicine recorded. All patients were contacted to discuss the risks of this medicine and establish the day of the week they take the medicine. The day of the week was then added to the prescription. The second audit undertaken in September 2022 showed all patients now had the day of the week documented.
  - An audit which looked at the management of patients on Dual Antiplatelet Therapy (a combination of two types of medications that can prevent blood clots), to ensure it was in line with evidence-based guidance and does not exceed the indicated 12-month duration. Patient records were reviewed to ensure the indication for the treatment and duration was recorded. The audit showed improvement between the first audit in June 2022 and the second audit in September 2022.



## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The provider had identified mandatory training requirements for staff and online training was made available to them for this. The sample of training records seen showed most staff were up to date with their training requirements.</li><li>• We saw evidence of audits undertaken of non-medical clinical staff working at the practice to ensure their competence.</li><li>• Staff told us how the practice was supportive of training and development to meet the needs of the service.</li><li>• Staff told us they received regular one to one discussions and annual appraisals which enabled them to discuss any learning and development needs. New staff received inductions for their roles. Records seen confirmed this.</li></ul>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <p>The practice held monthly meetings to discuss some of the practice's most vulnerable patients (those that were frail, housebound and on the palliative care register). Community and palliative care staff were invited to the meetings but were not always able to attend. However, staff told us that they still shared information through other means.</p>	

## Helping patients to live healthier lives

### Staff were 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 offered health checks to new patients registering with the practice and NHS health checks to patients aged 40 to 74 years, which enabled them to identify any health risks and provide appropriate support and guidance to patients.</li> <li>Patients were encouraged to attend cancer screening programmes and vaccination programmes as relevant.</li> <li>Patients at risk of developing diabetes were referred to the national diabetes prevention programme.</li> <li>The practice referred or signposted patients to various services offering lifestyle support including smoking cessation, weight management and talking therapies.</li> <li>Through the Primary Care Network (PCN), the practice was able to offer services such as social prescribing and physiotherapy.</li> </ul>	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff had access to consent policies including those relating to the Mental Capacity Act.</li> <li>There was a formal consent form for minor surgery. The practice advised that they had not carried out any minor surgery at the practice since the pandemic. Verbal consent was recorded directly in the patient notes.</li> <li>As part of the inspection we reviewed DNACPR decisions. We found one patient with a DNACPR in place that had been undertaken by the palliative care team and shared with the practice. The form included a clear rationale for the decision, assessment of capacity and evidence of discussion with appropriate persons.</li> </ul>	

## Well-led

**Rating: Good**

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Leaders understood and acknowledged the challenges impacting on the delivery of the service including deprivation and health inequalities which they were working with their local Primary Care Network (PCN) to address.</li><li>• Leaders acknowledged that having a small practice made it more challenging in what the practice could achieve. However, the provider told us that they had a second practice close by which enabled them to develop and share a more diverse staff skill mix between the two practices. Working with the PCN also provided opportunities to develop and provide additional services to their practice population.</li><li>• Staff we spoke with found practice leaders visible and approachable. They also told us of the opportunities they had been given to develop in their role.</li></ul>	

### Vision and strategy

**The practice had not formally documented their vision and strategy but were able to tell us how they planned to provide high quality 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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Although we saw no formal documented plan, staff were able to tell us about the vision for the practice, which related to improving care for the local population, through working with the PCN.</li><li>• The practice vision and values, and mission statement were shared with staff as part of their induction.</li><li>• The practice had set itself targets to try and drive standards of care.</li><li>• Staff also told us that they were in discussions with the landlord to improve the building but the pandemic had delayed progress with this.</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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff were very positive about the culture of the practice and told us that there was a supportive staff team in place.</li> <li>Staff felt able to raise concerns or feedback and told us that there was a no blame culture if they wanted to raise anything.</li> <li>The practice manager and principal GP were the Freedom to Speak Up Guardian's for the practice.</li> <li>Staff understood 'duty of candour' and were able to give examples as to how this had been implemented when things had gone wrong.</li> <li>We saw from a sample of records reviewed that staff had access to and were up to date with Equality and Diversity training.</li> </ul>	

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

Source	Feedback
Staff interviews	Staff told us that the practice team was supportive and that they prided themselves in being an open and honest practice that learned from their mistakes.

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff had access to policies and procedures that were regularly updated.</li> </ul>	

- There were comprehensive meeting structures in place that were inclusive of all staff and ensured important information was shared throughout the practice team. Minutes of meetings were available for those who were unable to attend the meetings.

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice regularly discussed performance at the weekly practice meetings and identified targets to help achieve goals.</li> <li>• The practice also used regular meetings to discuss areas for improvement for example, recent deaths, complaints and any significant events.</li> <li>• The practice had a Business Continuity Plan which set out the arrangements in the event of a disruption to the running of the service.</li> <li>• A range of risk assessments including fire, legionella and health and safety were in place. We found systems in place to manage other areas of risk including risks relating medical emergencies, medicines management and infection prevention and control.</li> </ul>	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Prior to the pandemic the practice had set up an online appointment system which enabled the GPs to prioritise patients and identify those that needed to be seen face to face. This enabled the practice to adapt to the pandemic quickly and easily. The practice has continued to use and embed this system. The practice told us that patients who might be digitally excluded could call the practice and the staff would use the online appointment system for them. The latest national GP patient survey data (published in 2022) showed patient satisfaction with access to the GP practice was similar to local and national averages.</li> <li>Staff told us that they had managed any backlogs caused by the pandemic. Internal targets were used to try and ensure patients returned for reviews of their health conditions.</li> <li>Additional infection prevention and control measures had been put in place as a result of the pandemic which included the use of face masks, provision of hand sanitiser, additional time allocated to enable staff to clean rooms between patients and social distancing measures in the waiting area.</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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Data was used to monitor and improve performance with systems in place for regular clinical searches in areas such long term conditions and medicine management.</li> <li>The systems in place to monitor performance had been embedded, this was supported by the findings of our clinical searches and reviews of patient records.</li> </ul>	

## Governance and oversight of remote services

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

The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice made use of online systems for requesting appointments, patients were required to bring identification and were given a security code to use the system.</li> <li>Staff we spoke with told us that they asked questions to confirm a patient identity when consulting with them remotely.</li> <li>The practice provided secure links for patients to send photographs and other information securely.</li> <li>There was a certificate available to show the practice was registered with the Information Commissioner's Office and this was in date.</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 had a patient participation group that met on a three month basis. We saw that the practice manager and principal GP had attended meetings to discuss and receive feedback from patients about the service.</li> <li>Results from the latest GP national patient survey (published in July 2022) showed questions about access were in line with local and national averages although those relating to patient experience were lower than local and national averages. The practice advised due to the small number of responses they were currently undertaking an inhouse survey to try and understand the patients' concerns. Online reviews about the service such as those on the NHS website, showed an even mix of positive and negative feedback.</li> <li>The practice held regular meetings which were inclusive of all staff and held one to one meetings where staff had opportunities to raise their views.</li> <li>The practice engaged with their local Primary Care Network; this is a group of local GP practices that work together to address local priorities.</li> </ul>	

## Feedback from Patient Participation Group.

Feedback
We spoke with a member of the practice's Patient Participation Group (PPG), they were very complimentary about the service. They confirmed that the practice held regular PPG meetings which



was attended by approximately five to ten people. They felt listened to and gave an example of issues raised that the practice had actioned for example, seeing patients who were unable to use the stairs and preferred not to use the lift on the ground floor.

## Continuous improvement and innovation

**There was little 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: <ul style="list-style-type: none"> <li>• Staff had access to training and were supported to development.</li> <li>• Staff were particularly proud of the work they had undertaken with regards to the appointment system which had improved access. There were clear protocols in place to ensure there was clinical input for prioritising and ensuring those that needed to be seen face to face were. There were some positive comments from reviews seen about the online system for requesting appointments.</li> <li>• Staff had developed effective systems for recalling patients, for example, given the challenging demographics of the practice population we saw some high uptake rates for child immunisations.</li> <li>• The practice had carried out medicines audits that had led to improvements in safer prescribing.</li> <li>• The practice made use of internal and external reviews of incidents and complaints to make improvements and share learning.</li> </ul>	



## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.