

## Inspection Evidence Table

Pak Health Centre - R Bhatti

(1-549486760)

**Inspection Date: 16 January 2023**

Date of data download: 05/01/2023

## Overall rating: Requires Improvement

The practice was previously rated inadequate overall, this was because we identified concerns relating to the governance of the practice and the safe care and treatment of patients. At this inspection, the practice has moved to an overall rating of requires improvement in recognition of action taken by the provider to improve the services delivered. The practice has made significant progress, however, we identified areas where improvement was still needed.

### Safe

### Rating: Requires Improvement

The practice was previously rated as inadequate for providing safe services because not all clinical staff had received the appropriate level of training for safeguarding; professional registration for relevant staff was not routinely monitored and portable appliance testing was overdue. The practice did not have effective systems in place for managing fire safety and infection prevention and control. Information recorded in clinical records was not always complete and potential backlogs in summarising records had not been fully addressed. We identified issues in relation to the management of medicines and safety alerts, and incidents were not being effectively used to support clinical learning.

At this inspection we have rated the practice as requires improvement as we found the practice had made significant improvements in addressing the concerns raised at our previous inspection. However, we identified areas relating to the prescribing of medicines, the practice's safeguarding processes and the latest fire risk assessment where further work was still needed.

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
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Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At our previous inspection in May 2022 we identified concerns with the safeguarding process, it was not clear that policies and procedures were embedded and not all clinical staff had received safeguarding training to an appropriate level.</li> <li>• At this inspection we found improvements had been made. The practice had in place a safeguarding policy which had been updated to reflect the safeguarding lead and their deputy and contained contact information for relevant agencies involved in safeguarding. Safeguarding information was also available in the clinical rooms for staff reference.</li> <li>• Training records showed that clinical and non-clinical staff were now trained to an appropriate level for their roles. Staff had also undertaken training to become an IRIS practice (Identification and Referral to Improve Safety) to better support those at risk of domestic violence.</li> <li>• Staff we spoke with had a good understanding of safeguarding and knew who the leads were and where to access policies when needed.</li> <li>• We saw improvement in the use of clinical system alerts on patient records to identify patients who were at risk of harm. However, our clinical searches found that these did not always extend to all family members. Staff told us that this was work in progress.</li> <li>• We saw minutes from quarterly multi-disciplinary meetings where safeguarding concerns were routinely discussed with the health visitor.</li> <li>• We saw that Disclosure and Barring Service (DBS) checks were in place for staff working at the practice. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.</li> <li>• Records seen showed that staff who acted as chaperones received appropriate training and were DBS checked.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection in May 2022, the practice did not have a system for the ongoing monitoring of staff professional registrations to ensure they were kept up to date. At this inspection we found records of up to date professional registrations were maintained.</li> <li>At our previous inspection in May 2022, we saw staff immunisation records in place that did not contain all relevant information in line with recommended guidance and no risk assessments undertaken where information was not available. At this inspection, from the 2 staff files reviewed we saw that files contained relevant information relating to staff immunisations, and risk assessments were in place when information was not available.</li> <li>At this inspection we saw appropriate recruitment checks had been made for the 2 staff files reviewed.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment:	Y
There was a fire procedure.	Y
Date of fire risk assessment: 25 October 2023	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection in May 2022 we found the practice did not have effective fire safety arrangements, actions from their fire risk assessment had not been adequately implemented, systems for testing fire alarms and fire drills were not embedded and nominated fire wardens had not received training.</li> <li>At this inspection we found that the practice had put in place systems for the weekly testing of fire alarms, had carried out a fire drill in the last six months and had ensured the nominated fire wardens had received appropriate training for the role. The practice had held a face to face fire safety training session so that staff would know what to do in the event of the fire.</li> <li>Since our last inspection, a new fire risk assessment had been carried out. This showed that progress had been made in addressing the actions from the previous fire risk assessment. However, the new fire</li> </ul>	

assessment had identified further actions that needed to be addressed. Information provided by the practice following the inspection showed that the actions had partially been addressed.

- Records seen showed that fire equipment, alarms and emergency lighting had been serviced in the last 12 months.
- The practice had a Health and Safety policy and risk assessments in place. Training records showed that most staff were up to date with their health and safety and fire safety training.
- At our previous inspection in May 2022 we saw portable appliance testing (PAT) of electrical equipment was overdue. At this inspection we found both calibration and PAT testing had been completed within the last 12 months.

### Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• At our previous inspection in May 2022 we found the practice did not have effective systems for managing infection prevention and control (IPC). The IPC lead had only just been allocated the role prior to the May 2022 inspection. There was a lack of evidence of regular IPC audits having been carried out or of audits effectively identifying areas for action. There were also gaps in staff IPC training, including the IPC lead.</li> <li>• At this inspection we found that the IPC lead had been given support from the Integrated Care Board (ICB) for the role and they were given protected time to carry out IPC duties.</li> <li>• Training records showed all but one member of staff were now up to date with their IPC training and the practice's IPC policy had been updated to support staff.</li> <li>• We reviewed the practice's latest IPC audit, which identified areas for action. A follow up audit in December 2022 showed progress against the actions identified. Staff were able to tell us about some of the actions that had been implemented. During our onsite visit we saw that IPC issues identified at our previous inspection had been addressed.</li> <li>• There was a legionella risk assessment in place and evidence of staff taking action to minimise the risk of legionella including water testing and flushing of water outlets.</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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had identified additional staff requirements and were working towards filling these. Staff we spoke with felt workloads were manageable and told us they would support each other during absences.</li> <li>• There was a rota system in place to ensure tasks were completed on a daily basis, enabling staff to focus on specific duties.</li> <li>• Staff were up to date with basic life support and sepsis training and knew where to find the emergency medicines and equipment when needed.</li> </ul>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. 1	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Explanation of any answers and additional evidence:

- At our previous inspection in May 2022 we identified an inconsistent approach to the management of pathology results with a backlog of results that needed processing. At this inspection we found that a consistent process was in place which enabled the practice to maintain effective oversight that test results were being managed in an appropriate and timely way.
- At our previous inspection there was a large backlog in the summarising of new patient records received. At this inspection, there was a dedicated member of staff responsible for the summarising of new patient records. The practice shared with us information that showed the backlog had significantly reduced.
- At our previous inspection in May 2022 we found information was not always recorded in patient records in a comprehensive way, for example in relation to medicines reviews, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions, and safeguarding alerts for all household members. At this inspection we found improvements in the detailed recording of medicine reviews and DNACPRs, and the practice was working to ensure safeguarding alerts for all family members was recorded.

**Appropriate and safe use of medicines**

**The practice had made significant improvements to the systems for the appropriate and safe use of medicines, including medicines optimisation. However, we found one area for improvement in relation to the prescribing of medicines safely.**

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) (01/10/2021 to 30/09/2022) (NHSBSA)	0.74	0.83	0.82	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). (01/10/2021 to 30/09/2022) (NHSBSA)	6.3%	7.7%	8.5%	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 (01/04/2022 to 30/09/2022) (NHSBSA)	5.11	5.16	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	77.9‰	116.0‰	129.6‰	No statistical variation

Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.88	0.60	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	7.7‰	7.8‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y

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

- At our previous inspection in May 2022 we identified issues relating to the safe management of medicines, this included concerns associated with the quality of documented medicine reviews and lack of effective systems for ensuring the monitoring of patients on high risk medicines.
- At this inspection our clinical searches and reviews found improved systems and processes for the management of medicines, for example:
- We identified 8 patients on DMARDs (Disease-modifying antirheumatic drugs) requiring routine monitoring due to the risk of significant side effects. We reviewed a sample of 5 of these records and found appropriate monitoring and follow up in place.
- We saw improvement in the recording of the day of the week to reduce the risk of potential overdose in relation to a particular DMARD. We also found improvement in relation to the issuing of emergency steroid cards for patients prescribed steroids on multiple occasions.
- We identified 9 patients on 2 high risk medicines requiring routine monitoring due to the risk of significant side effects. We reviewed a sample of 5 of these records and found patients were being prescribed and monitored in secondary care. The practice had taken appropriate action to follow up patients and ensure information recorded in secondary care was documented in their records to enable clinical staff to check for potential drug interactions.
- The practice had undertaken 171 medicine reviews in the last three months. We reviewed a sample of 5 of these records. Reviews seen were well documented and recorded appropriate checks having been carried out.
- However, our clinical searches identified 26 patients over 70 years on antiplatelet medicine (used to prevent blood clots) who were not on additional medicines to help protect their stomach from the antiplatelet medicine, in line with guidance. Patients in this age group have a higher risk of developing gastrointestinal bleeding. We reviewed five of the 26 records and found no clear rationale for not prescribing stomach protecting medicines in four out of the five cases. Following the inspection, the practice provided assurance that these patients had all been reviewed.
- Nationally reported prescribing data showed the practice was in line with other practices locally and nationally. We saw that local antibiotic prescribing guidelines were available to clinical staff in their rooms.
- Since our previous inspection the practice was being supported by two pharmacists, one directly employed and one through their primary care network (PCN). Both were independent prescribers. We saw that an audit had been undertaken of their prescribing competence by the lead GP partner.
- At our last inspection in May 2022 we found that a risk assessment had not been completed in the absence of a recommended emergency medicine. At this inspection we found that all recommended emergency medicines were stocked.



**Track record on safety and lessons learned and improvements made**  
**The practice learned and made improvements when things went wrong.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	14
Number of events that required action:	14
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in May 2022 we found the practice could not demonstrate they had systems in place to report and learn from clinical and non-clinical incidents. At this inspection, we found improvement in the reporting and learning from both administrative and clinical incidents.</p>	

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

Event	Specific action taken
Sample labelled incorrectly	<ul style="list-style-type: none"> <li>• Incident investigated and discussed with staff member involved for reflection.</li> <li>• Affected patients contacted and received an apology.</li> <li>• Patients advised that their test needed to be redone in 3 months.</li> <li>• Incident assessment form sent from Public Health England for completion.</li> <li>• Incident discussed and shared at practice meeting.</li> </ul>
Cold chain breach.	<ul style="list-style-type: none"> <li>• Issues with the fridge reported to the clinical team.</li> <li>• Vaccines moved to another fridge.</li> <li>• Data logger checked and found to have been high for short time only.</li> <li>• Fridge serviced.</li> <li>• Staff received refresh training on the cold chain policy.</li> </ul>

Safety alerts	Y/N/Partial
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There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the last inspection in May 2022 we found that the practice did not have an effective system for managing safety alerts. There was little evidence as to what actions had been taken in response to alerts received by the practice and our clinical searches identified Medicines and Healthcare Products Regulatory Agency (MHRA) alerts that had not been acted on.</li> <li>At this inspection we found the practice had significantly improved the systems for managing safety alerts. As part of the inspection we reviewed the practice's response to four MHRA alerts (two of which were the same as our previous inspection to see if improvements had been made). We saw that patients who had previously been identified in our clinical searches as being on drug combinations that should not be prescribed together due to the negative impact of doing so had been reviewed and were no longer on the combination of these medicines. We also found patients on two other medicines where there were potential risks had been made aware and given appropriate advice.</li> </ul>	

## Effective

## Rating: Requires Improvement

The practice was previously rated as inadequate for providing effective services because care and treatment were not consistently delivered in line with current legislation, standards and evidence-based guidance. There was low uptake of child immunisation and cancer screening programmes and a lack of clear programmes for quality improvement. Not all staff received opportunities for regular appraisals and systems in place were not effective in ensuring all staff were up to date with required training. There was also a lack of evidence that patients' wishes were discussed as part of end of life care.

At this inspection we have rated the practice as requires improvement as we found the practice had made improvements in addressing all the concerns raised at our previous inspection. This included improvements in relation to quality improvement activity, staff appraisals, training uptake and management of end of life decisions. Although, the practice had reviewed systems and processes to improve the low uptake of child immunisations and cancer screening programmes these had yet to demonstrate any improvements. We also identified some areas for improvement during our clinical reviews.

*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

**The practice was making positive progress to ensure patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
The practice prioritised care for their most clinically vulnerable patients	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in May 2022 we identified concerns such as medicines safety alerts that had not been addressed, lack of timely monitoring of patients' medicines and long-term conditions and no evidence that discussions around end of life care were taking place.</p> <p>At this inspection we found the practice had made improvements in relation to the safe management of medicines and long-term conditions. Our clinical searches found that the practice had made significant progress in ensuring patients received appropriate follow up and monitoring but were aware that this was still work in progress. The practice advised they were prioritising any backlogs on their most vulnerable patients first. Areas identified for improvement related to the completion of medicine reviews for patients with hypothyroidism and the prescribing of medicines to protect the stomach of those on antiplatelet medicines who were at higher risk of developing gastrointestinal bleeding, in line with guidance.</p> <p>Since our previous inspection we saw that end of life discussions were now taking place where appropriate with patients and their representatives.</p> <p>At our previous inspection we found little evidence of discussions relating to evidence-based practice or networking opportunities for clinical staff. At this inspection the practice was actively working with their new primary care network, the Royal College of General Practitioners and the Integrated Care Board to deliver improvements. Practice meetings were providing greater opportunities for staff to discuss clinical issues and updates.</p>	

## Effective care for the practice population

### Findings

- The practice told us that they identified older patients who were living with moderate or severe frailty and that those identified received a full assessment of their physical, mental and social needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients eligible to have the meningitis vaccine, for example before attending university for the first time, were able to receive this. Staff told us that system alerts were used to help identify those eligible.
- 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. Data available from the practice showed that 76% of eligible patients had received their annual review since April 2022.
- 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 told us that patients who misused substances were signposted to appropriate services locally for their needs.
- The practice told us that the GPs took the lead for assessing and monitoring the physical health of people with mental illness, severe mental illness, and personality disorder, including those with dementia and would refer to appropriate services, where needed.

## Management of people with long term conditions

### Findings

- At our previous inspection in May 2022, we found the management of patients with long term conditions to be variable. At this inspection, we found the practice had made significant improvements and that patients with long term conditions were being generally well managed, for example:

Our clinical searches found no patients with a potential missed diagnosis of diabetes or chronic kidney disease based on blood results. Those whose blood results indicating they were at risk of developing diabetes were appropriately coded and had received a review in the last 12 months.

Our clinical searches identified 13 patients with later stage Chronic Kidney Disease, all had received kidney function monitoring within the past 9 months. This was an improvement from our previous inspection.

Our clinical searches identified 8 patients out of 202 with asthma that had been prescribed 2 or more courses of steroids in the last 12 months (an indication of poor asthma control). We reviewed the records for five of these patients and found all had received an annual asthma review and had been reviewed following their course of steroids. However, the review of steroids was not always within a week of being prescribed, as recommended to check for improvement. We saw evidence of steroid emergency cards being issued as per MHRA advice, which was an improvement from our previous inspection.

Our clinical searches identified 72 patients with hypothyroidism, all had received appropriate blood monitoring. However, in the sample of 5 patient records reviewed, 3 patients were overdue their medicine reviews. The practice advised that they had been working on backlogs of medicine reviews since our last inspection but had been prioritising those who were most vulnerable first.

Our clinical searches identified 18 patients with diabetic retinopathy (a diabetic complication affecting the eyes) whose HbA1c (a test for blood sugar levels) was over 74mmol/l, indicating poor diabetic control and increased risk of diabetic complications. We reviewed the records for 5 of the patients identified, all had received appropriate follow up. This was a significant improvement on our previous inspection.

- The practice had made efforts to improve and embed the call and recall of patients with long term conditions, to offer patients a structured effective annual review to check their health and medicines needs were being met.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. The practice had access to a diabetes consultant who was able to support the care of patients with complex diabetes needs.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were asked to undertake home blood pressure monitoring, and were offered blood pressure monitors to do this, if needed.
- The practice advised that they had made a decision not to offer rescue packs to patients with COPD due to misuse and they signposted patients to other urgent services if needed.

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))(UKHSA COVER team)	44	62	71.0%	Below 80% uptake
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))(UKHSA COVER team)	46	64	71.9%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021))(UKHSA COVER team)	46	64	71.9%	Below 80% uptake

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) <sub>(UKHSA COVER team)</sub>	44	64	68.8%	Below 80% uptake
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) <sub>(UKHSA COVER team)</sub>	49	74	66.2%	Below 80% uptake

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

### Any additional evidence or comments

- The practice was well below the WHO based uptake target of 95% for childhood immunisations (the recommended standard for achieving herd immunity) and the minimum 90% uptake target for all childhood immunisation indicators. There had been a general decline in uptake over the previous five years. However, the latest published childhood immunisation data had not been updated since our previous inspection in May 2022.
- Since our previous inspection, the practice had developed an action plan to improve childhood immunisations. The practice had identified nominated administrative and clinical leads for childhood immunisation. Parents who declined invites were booked in with the nurse, where possible, so that they could discuss the benefits and address any concerns. Patients that still declined were asked to complete a disclaimer. Those that did not attend were contacted on the day. The practice also had a policy for children who were not brought for appointments which they followed for those that repeatedly did not attend.
- Practice staff told us that they had a significant Romanian population and would book longer appointments with them so that they had time to discuss and educate on immunisations.

Cancer Indicators	Practice	SICBL average	England	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). (30/06/2022 to 30/06/2022) <sub>(UKHSA)</sub>	57.1%	N/A	80.0%	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) <sub>(UKHSA)</sub>	31.1%	52.5%	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) <sub>(UKHSA)</sub>	29.5%	55.5%	66.8%	N/A

### Any additional evidence or comments

- Uptake of cervical screening was below the national target of 80%. The latest snapshot data showed little change in uptake over time.
- Since our previous inspection the practice had developed an action plan to improve the uptake of cervical screening. This had included inviting patients to discuss their concerns with the practice nurse if they did not want to take the test.
- Bowel and breast cancer screening programmes were below local and national averages. However, there had been no newly published data since our previous inspection.
- Information was displayed within the practice to encourage patient uptake on cancer screening programmes.

**Monitoring care and treatment**

**The practice was able to demonstrate improvements in quality improvement activity to review the effectiveness and appropriateness of the care provided.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in the past two years:</p> <ul style="list-style-type: none"> <li>• At our previous inspection in May 2022 we found limited evidence of quality improvement activity at the practice. At this inspection, we found the practice had undertaken several clinical audits which they shared with us.</li> <li>• The first audit was a two cycle audit which assessed the safe prescribing and monitoring of medicines used to treat high blood pressure and heart failure. The practice compared prescribing against various standards. The baseline audit in September 2022 showed the practice was not meeting all the standards set. However, a repeat audit in October 2022 showed improvement, with all standards met.</li> <li>• Since our previous inspection the practice had also undertaken baseline audits to assess the safe prescribing of medicines used in anticoagulant therapy and for an anti-psychotic medicine. Standards were set across various criteria and identified some areas for action and follow up. Re-audits were planned in 12 months to identify improvements made.</li> </ul>	

**Any additional evidence or comments**

The practice was also able to show improvements in the quality of audit processes such as infection prevention and control since our previous inspection in May 2022.

**Effective staffing**

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At our previous inspection in May 2022 we found there was a lack of clear and effective systems for monitoring staff training requirements. Not all staff had received induction training or had received opportunities to discuss learning and development needs through formal appraisals.</li> <li>• At this inspection, we found staff were up to date with the practice’s mandatory training requirements.</li> <li>• Staff files reviewed showed that new members of staff were receiving induction training and other staff had access to appraisals.</li> <li>• Records showed that staff employed in advanced clinical practice or with extended roles had received appropriate training for those roles.</li> <li>• Audits had been carried out for non-medical prescribing staff of their work and competence.</li> </ul>	

**Coordinating care and treatment**

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

	Y/N/Partial
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Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice held quarterly multidisciplinary team (MDT) meetings in which they invited community health staff to attend to discuss some of their most vulnerable patients.</li> </ul>	

### 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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Staff told us that patients at risk of diabetes were referred to a structured diabetes education programme.</li> <li>Our clinical reviews showed that patients at risk of developing diabetes were followed up appropriately.</li> <li>The practice offered relevant patients NHS Health Checks and had completed 42 so far this year.</li> <li>The practice provided inhouse smoking cessation support.</li> <li>Patients requiring support for mental health were referred or sign posted to counselling services available.</li> <li>Since our previous inspection the practice had joined a Primary Care Network and was able to access social prescribing support for their patients for non-medical health and wellbeing issues.</li> </ul>	

### 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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Clinical staff we spoke with had an understanding of relevant guidance and legislation in relation to consent in adults and children. Training records seen showed that staff had received training in mental capacity.</li><li>At our previous inspection in May 2022 the practice was unable to provide us with any examples of DNACPR decisions. At this inspection we saw that DNACPR decisions had been recorded and that where possible patients' views had been sought and respected in relation to end of life care.</li></ul>	

## Caring

## Rating: Requires Improvement

The practice was last rated as good for the Caring key question in September 2019. The good rating was carried over in the May 2022 inspection.

At this inspection we have rated the practice as requires improvement for providing Caring services because there had been a significant decline in the feedback from patients relating to their experience of the service. There had also been a fall in the identification of carers to ensure they received appropriate support.

### Kindness, respect and compassion

**There was mixed feedback about the way in which staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Discussions with staff demonstrated that they had an understanding and awareness of the importance of person-centred care.</li></ul>	

<ul style="list-style-type: none"> <li>Staff received training in equality and diversity.</li> </ul>	
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Patient feedback	
Source	Feedback
Patient interviews	The two patients we spoke with were positive about the service they received.
NHS Website	The practice had received six reviews on the NHS Website in the last 12 months. All were negative. Comments included concerns relating to access, staff attitude and calls not being returned.
Google reviews	The practice was rated 1.8 out of 5 stars based on 55 reviews. There were 15 reviews given in the last 12 months. These were mixed. There were positive and negative comments made about staff attitude and negative comments about calls not being answered.
CQC Enquiries	Since the previous CQC inspection in May 2022, CQC has received two enquiries both of which were negative comments including difficulties with access and lack of care.
Friends and family test (FFT)	The practice participated in the (FFT) which asks patients to rate the practice. We reviewed the latest 6 months of data from July to December 2022 of which there were 67 responses, 50 people rated the practice as good or very good (75%) and 14 poor or very poor (21%). This was an improvement on previous data seen for January and March 2022 where 57% of patients had rated the practice good or very good.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	58.2%	80.4%	84.7%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	53.9%	78.5%	83.5%	Significant variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	78.8%	90.5%	93.1%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall	44.6%	65.0%	72.4%	Variation (negative)

experience of their GP practice (01/01/2022 to 30/04/2022)				
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**Any additional evidence or comments**

- Results from the latest GP National Patient Survey published in July 2022 showed a sample of questions relating to the patient experience were approximately 20% below local and national averages. All of the scores for the sample questions had significantly declined since the previous GP National Patient Survey published in 2021. For example:
  - The percentage of respondents who stated that the last time they had a general practice appointment the healthcare professional was good or very good at listening to them, fell from 81.4% in 2021 to 58.2% in 2022.
  - The percentage of respondents who stated that the last time they had a general practice appointment the health care professional was good or very good at treating them with care and concern, fell from 67.4% in 2021 to 53.9% in 2022.
  - The percentage of respondents who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to, fell from 98.6% in 2021 to 78.8% in 2022.
  - The percentage of respondents in the GP patient survey who responded positively to the overall experience of their GP practice, fell from 75.7% in 2021 to 44.6% in 2022.
- The practice had produced an action plan to address some of the concerns raised in the GP National Patient Survey, this had focused on the areas the practice had scored the lowest. The practice was able to tell us about some of the things they were doing at the practice which they hoped would improve future results.
- It is also recognised that the data collection for the latest published GP National Patient Survey was prior to our inspection in May 2022 and before any changes being made by the practice.

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

**Any additional evidence**

Following the GP National Patient Survey, the practice undertook their own patient survey to monitor patient feedback. The survey showed greater patient satisfaction scores when compared with the GP National Patient Survey.

**Involvement in decisions about care and treatment**

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Our clinical reviews found improvements in the way in which patients were supported to understand their care and treatment.</li> <li>• Through the primary care network arrangements, patients were able to access a social prescriber to help them obtain information on other support services.</li> <li>• Staff made use of interpretation services when needed and many of the staff were able to speak with patients in their first language.</li> </ul>	

Source	Feedback
Interviews with patients.	We spoke with two patients who raised no concerns about their involvement in decision making about their care and treatment.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	66.7%	86.3%	89.9%	Variation (negative)

### Any additional evidence or comments

Results from the latest GP National Patient Survey found the percentage of patients who responded to the question on their involvement in decisions about their care and treatment was below local and national averages and had fallen from 95% in 2021 to 66.7% in 2022.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We saw information available to support patients whose first language was not English displayed in the practice.</li> </ul>	

- Staff we spoke with told us that they asked patients about any specific needs through the new patient registration forms and recorded this on their records.
- Staff also told us that they would offer extended appointments for patients that needed more time to understand their care and treatment needs.

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> <li>• There were 39 patients identified as carers on the practice list. This was 0.75% of the practice list. This was less than our September 2019 inspection.</li> </ul>
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>• The practice had identified a carers' lead and displayed information in the practice to support carers.</li> <li>• Staff told us that they were planning to send out a text messages to try and identify carers, and improve information so that they can better support carers.</li> <li>• Staff told us that carers were invited to attend health checks and flu vaccinations.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>• Staff told us that patients who were recently bereaved were sent messages about support services available to them.</li> </ul>

### Privacy and dignity

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

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Staff we spoke with were aware that they could take patients to a private room to speak if the patient wished and were able to give examples when they had done so.</li> <li>• The practice had recently refurbished the reception area to create private rooms in which calls could be made with more privacy.</li> </ul>	

## Responsive

## Rating: Requires Improvement

The practice was last rated as good for the Responsive key question in September 2019. The good rating was carried over in the May 2022 inspection.

At this inspection we have rated the practice as requires improvement for providing Responsive services because there had been a significant decline in patient satisfaction in the latest GP National Patient Survey relating to access. The impact of actions implemented have yet to be fully determined.

## Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had recently joined a local primary care network (PCN), a group of local GP practices working together to focus on local priorities and develop services for the local population.</li> <li>Since our previous inspection in May 2022, the practice had formed an action plan to improve services provided and were working to deliver this, this included an increase in availability of face to face appointments, additional clinical staffing and plans to recruitment further clinical staff.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	Phone lines 8am – 6.30pm Premises 9am - 6.30pm
Tuesday	Phone lines 8am – 6.30pm Premises 9am - 6.30pm
Wednesday	Phone lines 8am – 6.30pm Premises 9am - 6.30pm
Thursday	Phone lines 8am – 6.30pm Premises 9am - 6.30pm
Friday	Phone lines 8am – 6.30pm Premises 9am - 6.30pm
Appointments available:	
Monday	GP 9.30am – 12.30pm and 2pm – 6.30pm Pharmacist 9.30am -1pm and 1pm- 6.30pm Nurse 9am – 5pm
Tuesday	GP 9.30am – 12.30pm and 3.30pm – 6pm Pharmacist 9.30am - 6.30pm Nurse 9am – 5pm

Wednesday	GP 9.30am –1pm and 3.30pm – 5.30pm Pharmacist 9.30am -1pm and 2pm - 6.30pm Nurse 9am – 5pm
Thursday	GP 9.30am – 1pm and 2pm – 6.30pm Pharmacist 9.30am -1pm and 2pm - 6pm Nurse 9am – 1pm and 2pm – 6pm
Friday	GP 10am –1pm and 3.30pm – 6.30pm Nurse 9am – 5pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. This was an area of improvement from our previous inspection.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Nurse appointments were available until 5pm most days so that school age children did not need to miss school.
- Parents or guardians calling with concerns about a child were referred to the on-call GP to assess need.
- Extended access appointments were available by appointment through the PCN at various locations locally during evenings and at weekends.
- The practice held a register of patients living in vulnerable circumstances, for example for patients with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

#### Access to the service

**The practice had made changes to enable patients to access care and treatment in a timely way.**

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



There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Since our previous inspection the practice had reviewed staffing, they now had the support of two independent prescribers and were looking to further recruit additional clinical staff.</li> <li>• The practice had recently joined a PCN which enabled them to access a social prescriber.</li> <li>• An action plan had been developed in response to patient feedback and access. Actions taken to improve access have included additional clinical staffing, a phone system that enabled the practice manager to monitor calls, a staff rota to ensure there are dedicated staff to take calls and a target to reduce the time reception staff take to answer calls.</li> <li>• Patients were able to request face to face appointments if that was their preference. Appointments were made available on the day or were pre bookable in advance.</li> <li>• Patients were also able to obtain appointments up to 8pm weekdays and on a Saturday between 1pm and 7pm through the extended access hub arrangements.</li> </ul>	

### 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)	33.8%	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)	35.8%	47.4%	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)	40.6%	47.2%	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)	44.8%	67.1%	71.9%	Variation (negative)

**Any additional evidence or comments**

- Results from the latest GP National Patient Survey published in July 2022 were below local and national averages. There was also a downward trend for all of the sample access questions between 2021 and 2022. However, it is noted that the data was collected prior to our last inspection in May 2022 following which the practice had sought to make improvements to the practice and access to services.
- The practice had recently carried out their own in-house patient survey which showed higher scores than the GP national patient survey in response to questions about access. For example:  
  
65% of patients who responded said they found it easy to get through to the practice by phone.  
74% of patients who responded described their experience of making an appointment as good.  
75% of patients who responded said they were satisfied with the appointment times available.  
75% of patients who responded said they were satisfied with the appointment they were offered.

Source	Feedback
Online Reviews (NHS Choices / Google / Healthwatch)	Over the last 12 months there were some negative reviews regarding access to services.

### Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	9
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.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient unhappy that they had ran out of medicines and were required to make an appointment.	<ul style="list-style-type: none"> <li>• Complaint acknowledged the same day as received.</li> <li>• Information reviewed by the GP and agreed that the patient could be on repeat prescription.</li> <li>• Patient informed of the outcome.</li> </ul>
Patient relative unhappy with time taken for prescription to be produced.	<ul style="list-style-type: none"> <li>• Complaint acknowledged.</li> <li>• Incident investigated and found that the request had been made on a Friday and had been actioned by the Monday.</li> </ul>

	<ul style="list-style-type: none"> <li>Practice explained to the relative the procedure and timescales for prescription requests.</li> </ul>
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## Well-led

## Rating: Requires Improvement

The practice was previously rated as inadequate for providing well-led services. This was because the practice had been without clear leadership, governance arrangements were not fully-embedded and risks had not been effectively managed. The practice was also unable to demonstrate improvement.

At this inspection we have rated the practice as requires improvement as we found the practice was making positive improvements in addressing the concerns raised at our previous inspection. There had been changes within the clinical leadership of the practice who were actively working with other stakeholders to improve the services for patients. While we saw positive progress, further work was still required to fully deliver the improvement programme, effectively manage all risks and strengthen patient engagement.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels. Changes being made within the practice demonstrated that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At our last inspection there were concerns about the general leadership of the practice. The practice had recently recruited a practice manager after a two-year absence who was working to implement systems and policies that had been absent prior to their recruitment. The practice was also the only practice not aligned to a Primary Care Network (PCN) within the local Integrated Care System (ICS).</li> <li>At this inspection there had been changes within the clinical leadership who were now working closely with the Integrated Care Board (ICB) and the Royal College of General Practitioners (RCGP) and had developed an action plan to support service improvement. The practice was now working within a local PCN to help meet the needs of their local population which had led to additional support being made available to patients.</li> <li>The practice was working to develop their workforce and were participating in the ICB led Accelerate Programme in developing administrative staff skills to best support patient needs.</li> </ul>	

- We found there was more stability within the practice with the practice manager continuing to embed changes needed to ensure staff had clear policies and systems for delivering safe services.

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• At our previous inspection in May 2022 we found the practice had a strategy for developing the service but this was in need of review.</li> <li>• At this inspection the practice had developed action plans to develop and improve the practice. These were discussed with the practice team who were aware of their roles and responsibilities in delivering the plan to support service improvement.</li> </ul>	

### Culture

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

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

- At our previous inspection in May 2022 we found policies and procedures were not clearly embedded to support staff including those relating to Duty of Candour and Whistleblowing.
- At this inspection the policies had been reviewed and staff now had access to a Freedom to Speak Up Guardian independent from the practice.
- Staff were able to provide examples of duty of candour and how they had responded to this. Incidents seen included those of clinical and non-clinical nature with systems to discuss and learn from them in place.

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

Source	Feedback
Staff interviews	Staff we spoke with told us that there was a positive culture in the practice and that everyone was approachable. Staff felt able to raise concerns and make suggestions.

### Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At our previous inspection in May 2022 we found a lack of effective governance arrangements in place. The practice was unable to demonstrate that their policies and procedures were embedded. Staff allocated lead roles in areas such as safeguarding, fire safety and infection prevention and control had not received appropriate support and training.</li> <li>• At this inspection, we found staff with lead roles had received appropriate support and training for their roles. Policies and procedures had been reviewed to ensure they were up to date and fit for purpose. Staff we spoke with knew where to find these when needed.</li> <li>• The practice had continued to develop their governance arrangements and had strengthened meeting structures to ensure all staff were kept informed.</li> </ul>	

**Managing risks, issues and performance**

**The practice had improved the processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At our previous inspection in May 2022 we found that the practice did not have clear and effective systems for managing risks, issues and performance. We identified issues relating to the management of safety, equipment, infection prevention and control, safeguarding, incidents, staff supervision, safety alerts, business continuity plans, management of pathology results and medicine reviews and some long-term conditions.</li> <li>• At this inspection we found the practice had worked closely with their local ICB and the RCGP to improve the management and provision of services at the practice. They had taken significant action to address concerns raised at our previous inspection, many of the concerns had been addressed with systems now in place or were work in progress for example, in relation to the management of medicines and all long-term conditions.</li> <li>• Although the practice now had action plans in place to improve the service, they also still faced significant challenges in relation to improving cancer screening programmes, child immunisation and the identification of carers to enable them to access care and support. The GP National Patient Survey also showed a significant decline in patient satisfaction with the service.</li> <li>• The practice had recently joined a Primary Care Network (PCN) and were able to secure additional services for their patients including pharmacy and social prescribing support.</li> <li>• We saw that staff were able to discuss performance and risk through the practice meeting structures.</li> </ul>	

**Appropriate and accurate information**

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection in May 2022 we identified issues relating to information. For example, there was a lack of detail recorded in relation to medicines reviews, delays in the management of pathology results and follow up of audit findings.</li> <li>At this inspection, we found the practice had significantly improved the recording of medicine reviews, the management of pathology results now incorporated an audit trail and clinical audits shared with us demonstrated follow up of findings.</li> <li>We saw that information relating to performance and improvement was being discussed at the practice meetings.</li> <li>Since our inspection in May 2022 the practice had undergone partnership changes, however had not registered those changes with CQC. The practice advised us that there had been some issues with this and they were in the process of addressing them.</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.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p>	

- The practice had an information governance policy in place and was registered with the Information Commissioner's office (ICO).
- Staff advised that patients requesting online services were required to provide identification.
- An answerphone message was used to advise patients that calls were recorded.
- Trusted systems were used for patients to share information electronically as part of their consultation.

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

**The practice had made some progress to involve the public, staff and external partners to sustain high quality and sustainable care, although further work was needed to embed this.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At our previous inspection in May 2022 the practice was unable to fully demonstrate how they involved patients and external partners to sustain high quality and sustainable care. Although there had been some progress made, this needed time to become embedded.</li> <li>• The practice received feedback from patients through the GP National Patient Survey, In house patient survey, Friends and Family test and complaints.</li> <li>• The action plan in response to the GP National Patient Survey 2021 did not demonstrate that it had been effective in improving patient satisfaction as the latest survey scores for 2022 had significantly declined. A new action plan had been developed and included changes to the appointment systems and staffing..</li> <li>• The practice had a patient participation group (PPG) that had met once since our previous inspection, this had been during the inspection process. Members of the PPG had been informed about what was going on in the practice and discussed the importance of cancer screening programmes.</li> <li>• Since our previous inspection information on the practice website had been improved in supporting people to raise a complaint.</li> <li>• Staff were able to express their views and provide feedback through practice meetings and appraisal processes.</li> <li>• The practice had recently joined the Washwood Heath Primary Care Network (PCN) where they were now working with other practices in the area to address local priorities in patient care.</li> </ul>	

Feedback from Patient Participation Group.



## Feedback

We spoke with two members of the PPG who confirmed that they were part of the practice's group. They felt the practice listened to the members but were unable to provide any examples of changes made as a result of patient feedback.

### 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.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• At our previous inspection in May 2022 we found little evidence of systems and processes for learning, continuous improvement and innovation.</li><li>• At this inspection we found the practice was making progress in this area. There had been changes to the leadership of the practice who were working with external stakeholders to identify and develop comprehensive actions to improve the service. We found evidence that showed the practice was working hard to implement those actions to deliver service improvements.</li><li>• We found staff were receiving appraisals to discuss learning and development, there were improvements to the systems for learning from incidents and managing safety alerts and audits to support safe medicines management. The practice had gained additional support from their primary care network in relation to pharmacy support and social prescribing.</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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

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

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