

## Inspection Evidence Table

Park Street Surgery

(1-540175324)

**Inspection Date: 14 and 21 June 2023**

Date of data download: 23/05/2023

## Overall rating: Good

At this inspection, we found significant improvements in all the areas previously rated as inadequate or requires improvement at the previous inspection in November 2022. There were stronger systems to report, record and manage incidents. Procedures around safeguarding had improved. Medicines management had improved, and this was evidenced during the clinical searches. There was a strong programme of clinical audit, with demonstrable improved patient outcomes.

### Safe

### Rating: Good

At the last inspection in November 2022, we rated the practice as inadequate for providing safe services. This was because the practice did not always provide care in a way that kept patients safe and protected them from avoidable harm. We found inadequate systems to assess, monitor and manage risks to patient safety. At this inspection, we found significant improvements, including in the way safeguarding issues were recorded and communicated; and how information was managed in the practice including test results. We found improvements in the process for monitoring patients' health in relation to the use of medicines including high risk medicines. Not all infection control issues had been dealt with, however an action plan was in place, some works were booked in, and all other works due to be completed within a 3 month timescale.

#### Safety systems and processes

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

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

There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff demonstrated a good awareness of their roles and responsibilities with regards to safeguarding. There was a named safeguarding lead. There was safeguarding adults and children's policies, which had been recently reviewed, and staff knew where to access these. Staff were aware of and confident in safeguarding procedures and were able to give examples of where they had raised concerns.</p> <p>Records of multi-disciplinary safeguarding meetings, actions taken, and the updating and review of safeguarding registers had all improved since the previous inspection.</p> <p>Staff had DBS checks undertaken prior to appointment. There was no risk assessment in place for how often these were renewed, however the practice undertook one during the course of the inspection and as a result instigated a voluntary policy to renew these every 5 years.</p>	

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> <p>There were recruitment policies and procedures in place which had been recently reviewed.</p> <p>Staff files had relevant references and contracts. We could see some evidence that new staff had been asked for ID as part of their recruitment process, but copies or details (for instance, drivers license numbers) were not kept so we could not verify these had been received. The provider changed their policy on this as a result of the inspection.</p> <p>At the last inspection we found that the provider did not routinely maintain a record of all immunisations in line with The UK Health Security Agency (UKHSA) guidance. At this inspection, we found that record keeping had improved, with all relevant staff having had vaccination records maintained.</p>	

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:	Jan 2023
There was a fire procedure.	Y

Date of fire risk assessment:	April 2023
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that previous actions from fire risk assessments had not been implemented. At this inspection we found that there was now designated fire marshals and other required actions had been carried out.</p>	

**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:	March 2023
The practice had acted on any issues identified in infection prevention and control audits.	P
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The last inspection and an externally commissioned review of infection control highlighted issues which had been transferred to an action plan. This included replacement of carpet in consultation rooms and the provision of wipeable chairs. Although these works were not complete, the provider produced an updated action plan with brought forward dates for completion, or in some cases evidenced that works were booked in. New chairs were procured during the inspection. The provider had already dealt with other issues highlighted at the last inspection, including only carrying out procedures in already upgraded rooms, additional training for staff, and proper management of sharps bins. The infection control lead carried out 6 monthly and yearly audits. Although more frequent spot checks were undertaken, these were not documented and we discussed additional weekly and monthly checks. Daily cleaning schedules and completion sheets were in each room.</p>	

**Risks to patients**

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y

The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was an induction policy and procedures in place, and staff said they had been trained and settled in well. There was an induction pack for registrars. As a result of an audit on dependence forming medicines, the practice identified that locum doctors were not always party to all required information within the practice. This resulted in an improved and upgraded locum and registrar handbook, with additional signposting to clinical leads and the practice intranet pages.</p> <p>All relevant staff had now received sepsis awareness training. Staff told us they knew how to access emergency procedures and how to raise the alarm in the event of a deteriorating or acutely unwell patient.</p>	

**Information to deliver safe care and treatment**

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	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
<p>Explanation of any answers and additional evidence:</p> <p>There was considerable improvement in this area since the previous inspection when we found some delays in viewing and actioning results and clinical tasks. Our searches of the clinical records system showed systems for results, recalls and referrals were working well. All urgent results had been dealt with and the oldest routine result was from 2 days previously. There was a named clinical buddy system for checking results displayed prominently on the practice's intranet page. Staff were able to explain their processes and where to find the relevant protocols.</p> <p>We discussed how further improvements could be made to the process for urgent cancer referrals. Patients were appropriately advised to get back in touch with the surgery if they hadn't heard after a certain period of time. Failsafe options could be introduced where the practice actively searched the referrals to ensure these had been completed and the patient had attended.</p>	

## Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	0.98	0.89	0.86	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	6.2%	6.5%	8.1%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	4.77	4.94	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	138.6‰	136.2‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	0.39	0.46	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	4.3‰	4.6‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	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. 2	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
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
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>We found improvements in the process to ensure staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). All of the ones we checked had been appropriately signed and authorised, and the practice had made use of technology within their intranet site so that staff were notified when these documents were due for review.</p> <p>We checked at random 5 medication reviews, and found these had been conducted appropriately, with recorded outcomes, required monitoring or changes to treatment having been addressed.</p> <p>We found improvements in the process for monitoring patients' health in relation to the use of medicines including high risk medicines which required additional monitoring. The clinical searches for 2 types of medicines requiring monitoring showed patients had received appropriate monitoring, tests and review. We looked at the prescribing of gabapentinoids, (antiepileptic medicines which are also used for nerve pain), that patients can become dependent on. We found 2 out of 143 patients who were slightly overdue for a medicines review; one was booked in for a review and the other who was booked for review when we highlighted this to the provider.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <p>At this inspection, we found that the management oversight of near misses or errors in the dispensary had improved. Incidents had been recorded with learning points and were also raised at quarterly review meetings. There was a checking system in place which helped to reduce dispensing near misses by identifying errors before medicines were issued to the patient, and this appeared to be working well.</p> <p>At the last inspection we noted the dispensary to be very noisy as it was in the main reception area where patients presented and where receptionists answered the telephone. Staff told us then, that the dispensary was a difficult to area to concentrate in. At this inspection, we observed the same, however the provider had plans and was currently risk assessing moving the dispensary to a more remote, quieter room.</p>	

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

**The practice learned and made improvements when things went wrong**

Significant events	Y/N/Partial
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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:	39
Number of events that required action:	39
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that systems were not in place to ensure that safety information was consistently monitored and reviewed. Staff did not always know how to identify and report concerns, safety incidents and near misses. At this inspection, we found systems had much improved.</p> <p>Incidents were consistently recorded, with learning points and actions noted. Incidents were further discussed at quarterly review meetings. A Learning Event and Significant Event Policy was in place, with a named clinical lead. Staff knew how to access this, and how to report events. Staff told us they were encouraged to report events. We could see where actions had been taken by named persons.</p>	

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

Event	Specific action taken
Needlestick injury to staff member	Communications and protocols improved with occupational health and how to access details, changes made to procedures and equipment availability.
Patient given an injection before all relevant blood tests completed	New protocol and clinical template introduced

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that responsibilities for reviewing and actioning safety alerts were not clear, and the provider could not always demonstrate that actions had been reviewed.</p> <p>At this inspection we reviewed the practice Patient Safety Alert Policy, and found it contained a named clinical lead and other staff responsible for actions. We reviewed individual alerts and assessed that appropriate actions had been taken. The practice could still improve its overall management of safety alerts, including regular retrospective auditing of historical alerts to ensure these were actioned correctly at the time.</p>	



## Effective

## Rating: Good

At the previous inspection in November 2022, we rated the practice as requires improvement for providing effective services as we found patients care and treatment was not always provided in line with evidence-based guidance. We previously identified concerns in the management of patients' health conditions. At this inspection the provider was able to evidence improvements in patients care and the management of long-term health conditions. There was a comprehensive programme of clinical audit, and evidence of quality improvement initiatives improving patient outcomes.

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

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:  Patients who needed to be seen on the day would initially speak with the receptionists and were then added into a same day urgent slot, either face to face or telephone appointments depending on patient preference. Once these slots were filled, they were added to an overflow list. It was not clear on what actions would be	

taken if the practice had to go over the overflow list, however the practice had identified this and were intending on visiting other practices to identify good practice and how they could build resilience.

If the patient had a symptom of serious illness for example chest pain, they would be advised to call 999. If the receptionist was concerned about a patient, they were able to either phone or message the duty doctor for immediate advice.

Clinical staff were kept up to date with clinical guidelines and evidence-based practice through the practice intranet system, appropriate use of clinical templates for treatment pathways, clinical meetings and sharing of best practice. GPs had lead roles for their areas of clinical interest.

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. Health checks for this age group were paused during the COVID-19 pandemic. The checks had recommenced, with 382 checks having been completed from 1783 eligible patients.
- There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. Patients referred on a '2 week wait' cancer pathway were told to contact the surgery if they hadn't received their appointment. We discussed how the practice could improve this by actively searching for patients using clinical search tools to identify whether they had received and attended their appointment, as an additional layer of 'safety-netting'.
- All patients with a learning disability were offered an annual health check. The clinical lead had carried out extra training and looked at how to make the process of invite and review more accessible, with reasonable adjustments made. This included the ability to directly telephone the care co-ordinator to make review appointments.
- 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.
- 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.

The clinical review of patient records identified that in the vast majority of cases, patients' ongoing needs were assessed, and reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition.

We identified a small number of patients overdue for some monitoring, for instance 2 patients prescribed gabapentinoids, one of whom had been booked in for review and the other which was actioned after the inspection.

We looked at 5 medication reviews and found these had been carried out in a timely manner and contained all necessary information.

## Management of people with long term conditions

### Findings

- The clinical review of patient records identified that patients' ongoing long term condition needs were assessed. One patient was missing diagnosis of chronic kidney disease, which has since been addressed. Three patients with hypothyroidism were slightly overdue for annual medicines review but had been sent invites. Where patients had not responded to invites for annual reviews, we could see where further reminders had been sent.
- At the previous inspection, we found concerns with the management of patients with asthma, particularly in respect of patients with asthma who had had 2 or more courses of rescue steroids in the last 12 months. There was insufficient follow up and review of patients following an exacerbation of their asthma, including when treatment had been required at hospital or an out of hours service. At this inspection, we found this process had improved, with automated prompts for clinicians and admin staff to follow up patients within 48 hours. The practice had carried out a number of audits and were able to demonstrate since new protocols were introduced in March 2023, all patients had been coded and followed up appropriately. The practice had also introduced a programme of asthma multi-disciplinary meetings, and clinical leads had carried out extra training and shared best practice.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
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The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	60	62	96.8%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	60	61	98.4%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	60	61	98.4%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	59	61	96.7%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	72	84	85.7%	Below 90% minimum

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

#### Any additional evidence or comments

The latest data from the practice showed the percentage of children aged 5 who have received immunisation for measles, mumps and rubella to be at 94.1% (64/68), although these figures are as yet unpublished and unverified, therefore no statistical comparison can be made to previous years.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	66.3%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	77%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (31/12/2022 to 31/12/2022) (UKHSA)	75.3%	N/A	80.0%	Below 80% target

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	50.0%	57.6%	54.9%	No statistical variation
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### Any additional evidence or comments

The latest data from the practice showed 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) to be 87% (1426/1642), although these figures are as yet unpublished and unverified, therefore no statistical comparison can be made to previous years.

### Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:  At the last inspection, we found limited evidence of quality improvement activity. At this inspection, it was clear the practice had prioritised clinical audit and quality improvement, with 19 clinical audits carried out since the previous inspection. This included a 2 cycle audit for patients prescribed DOAC's (Direct-acting Oral Anti-Coagulants - blood thinning medicines), which demonstrated an improvement in management and review of these patients. Other projects carried out after the last inspection included a regular review of do not resuscitate (DNAR) forms, which over time showed improved record keeping and adherence to protocols. A 1 cycle review of how patients with chronic kidney disease were recorded and recalled for monitoring tests. This was due to be repeated in the autumn, but stronger clinical coding and recall systems implemented should demonstrate improved clinical outcomes.	

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y

The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
We found improvements in the management of staff since the previous inspection, particularly with regards to clinical and prescribing supervision and support. Staff told us they were well supported, had received sufficient training, and felt well supported within their roles.	

### Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
At the last inspection we identified delays in processing information, including test results. At this inspection, there was significant improvements in the way the practice managed the flow of information into and out of the practice. All urgent tasks had been dealt with and the oldest routine task was from 48 hours previously, on the day of the clinical searches.	

### Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y

Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
The practice promoted use of their social prescriber and had made 252 referrals in the last 12 months. Through the social prescriber, patients could be signposted to services such as weight management clinics.	

**Consent to care and treatment**

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
We found improvements in this area since the previous inspection. Our review of notes where a DNACPR decision had been recorded, identified that where possible the patients views and/or their representative had been sought and respected. Decisions had been clearly documented and were accessible to clinicians who needed it. We saw that information had been shared with relevant agencies. The practice regularly audited their compliance in these areas.	

**Caring**

**Rating: Good**

The last inspection in November 2022 was a focused inspection and caring was not inspected. The previous rating of Good from May 2016 therefore continued. We found at this inspection the provider had continued to maintain a rating of good for providing caring services.

**Kindness, respect and compassion**

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y



Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Patient feedback	
Source	Feedback
NHS Choices	2 reviews in the last 12 months, both positive
Patient feedback received by CQC	4 sets of feedback received in the last 12 months, all positive

### 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)	95.6%	90.0%	84.7%	Variation (positive)
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)	95.0%	89.8%	83.5%	Variation (positive)
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)	99.1%	95.7%	93.1%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	92.8%	82.7%	72.4%	Variation (positive)

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

Any additional evidence
The practice had not carried out its own patient survey but had analysed the results of the National GP Patient Survey and Friends and Family Test submitted feedback. They had acted on the results, for example restructuring appointment times and how these were allocated to increase the provision of the patients GP of choice.

## 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

## 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)	96.9%	93.4%	89.9%	Tending towards variation (positive)

	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

Carers	Narrative
Percentage and number of carers identified.	283/ 3%
How the practice supported carers (including young carers).	Information for carers was posted on social media and the practice website. There were information posters in waiting areas. Carers were directed to the Social Prescriber for support, who could signpost to wide range of support services.
How the practice supported recently bereaved patients.	Support and signposting were offered to relatives and carers

## Privacy and dignity

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

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

## Responsive

## Rating: Good

The last inspection in November 2022 was a focused inspection and responsive was not inspected. The previous rating of Good from May 2016 therefore continued. We found at this inspection the provider had continued to maintain a rating of good for providing responsive services.

### 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.	P
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
Explanation of any answers and additional evidence:	
There was an ongoing process of upgrading the building, fixtures and fittings to ensure that all points in infection control audits were addressed.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6pm
Tuesday	8am - 6pm
Wednesday	8am - 6pm
Thursday	8am - 6pm

Friday	8am - 6pm
Appointments available:	
Monday	8am -6 pm
Tuesday	8am - 6pm
Wednesday	8am - 6pm
Thursday	8am -6 pm
Friday	8am -6 pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Pre-bookable appointments for early mornings, evenings and weekends were also available to patients either at the practice or at additional locations within the area, as the practice was a member of the Yorkshire Health Network (YHN), a Federation of the 17 GP practices in the Harrogate and rural district.
- The practice held a register of patients living in vulnerable circumstances, for instance those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability and had recently carried out a consultation exercise with their patients as to how patients with learning disabilities would find it easier to book and attend their health checks.

### Access to the service

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

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

There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
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### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who 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)	82.5%	N/A	52.7%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	74.7%	68.7%	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)	73.2%	64.6%	55.2%	Tending towards variation (positive)
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)	84.0%	78.6%	71.9%	No statistical variation

### Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	14
Number of complaints we examined.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	6
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

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

It was not obvious from complaints received and responded to by email whether patients had been given a copy of the complaints procedure leaflet.

Example(s) of learning from complaints.

Complaint	Specific action taken
Problems with medicines prescribed and consultation manner	Meeting with patient, further consultations booked in, reflective practice undertaken.
Consultation manner	Apology given and reflective practice undertaken

## Well-led

## Rating: Good

At the last inspection in November 2022, we rated the practice as inadequate for providing well-led services because governance processes were inadequate to manage risk and the provider was unable to demonstrate effective and capable leadership.

At this inspection, we found significant improvements in governance. The provider had acted on previous inspection feedback and produced regular action plans for improvement. GPs had developed clinical and governance lead roles; and communication across the practice was good. On the whole, leaders demonstrated an open and reflective culture.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

At our last inspection, we found that lead roles had not always been allocated to key areas. We found significant improvement in this, with lead GPs able to demonstrate improvement in patient outcomes, for instance in the areas of asthma management and Do Not Attempt Cardio-Pulmonary Resuscitation ( DNAR) processes.

The practice had changed and upgraded many of their IT systems and were using these effectively to streamline and strengthen information flow. Improved patient outcomes could be demonstrated, for instance timely checking and actioning of results and referrals.

Staff feedback about leaders was positive, and there was a strong, cohesive team.

### 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:	
The practice had restarted a Patient Participation Group (PPG) since the previous inspection. There was some evidence of collaboration to drive improvement, for instance improvements to the practice website.	
There was an improved system of quality monitoring and improvement activity which should mean the provider is now more able to embed positive changes made and maintain an improvement trajectory. Staff felt invested in the provider and were clear on their roles and responsibilities.	

### Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y



When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff reported they felt confident in raising incidents or concerns and knew how to access procedures to do so. The processes for reporting and analysis of significant events had improved, with evidence of learning and dissemination of findings. Staff were able to give specific examples where procedures had changed as a result of an incident.</p>	

### **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
<p>Explanation of any answers and additional evidence:</p> <p>The overall governance systems for the practice were much improved, with stronger systems to identify and manage risk. Staff members took responsibility for their lead roles and communicated well with others. The provider made good use of automated systems to ensure reminders, review dates and tasks were received by the relevant staff.</p>	

### **Managing risks, issues and performance**

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider was able to demonstrate significant improvement in this area, with clinical audit and other quality improvement work driven from a variety of sources; including past inspection findings, areas of special interest for GPs and identification of areas for improvement following an incident.</p>	

#### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

#### Governance and oversight of remote services

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

The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Feedback from Patient Participation Group.

Feedback
Feedback from the recently reformed group was positive, although agreement on terms of reference and how the group would operate needed to be developed.

### 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

### Examples of continuous learning and improvement

The practice had developed an enhanced system of searches and clinical coding where staff would automatically be prompted to book patients in with the most appropriate clinical person and for the correct amount of time (for instance, a double appointment). Staff could easily see which tests or reviews needed to be completed as part of that booking. This was supported by protocols and flow charts, with additional training given to reception staff. The efficacy of these systems was evidenced by patient satisfaction around access to appointments, and the very low numbers of overdue monitoring found on the clinical searches.

Staff were linked into the practice intranet system by role, which enabled more efficient access to protocols for that staff member, for instance, in the event of needing to report an incident.

The practice was proactive in seeking areas of improvement, for instance trialling a system where hospital discharge summaries were automatically reviewed by a clinical lead rather than the patient's usual GP.

Changes were audited for improvements in patient outcomes and discussed in clinical meetings. We saw from clinical audit that patient outcomes had improved in the many areas, including asthma management, Hormone Replacement Therapy (HRT) prescribing safety, and chronic kidney disease monitoring and prescribing. There were many 2 and 3 cycle audits which clearly demonstrated continuous learning and improvement. Clinical leads took effective ownership of their areas, and we could see where changes to protocols were discussed and fed back to relevant members of staff.

**Notes: CQC GP Insight**

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

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

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