

# Care Quality Commission

## Inspection Evidence Table

### Bowburn Medical Centre (1-2502814101)

Inspection date: 1 – 7 December 2022

Date of data download: 29 November 2022

**Overall rating: Good**

**Safe**

**Rating: Good**

#### Safety systems and processes

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

| Safeguarding  | Y/N/Partial |
|---|-------------|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff.  | Y           |
| Partners and staff were trained to appropriate levels for their role.   | Y           |
| There was active and appropriate engagement in local safeguarding processes.  | Y           |
| The Out of Hours service was informed of relevant safeguarding information.   | Y           |
| There were systems to identify vulnerable patients on record.   | Y           |
| Disclosure and Barring Service (DBS) checks were undertaken where required.   | Y           |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.  | Y           |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice staff training matrix showed that staff had all received the appropriate level of training</li><li>The practice had regular meetings and safeguarding was always a set agenda.</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           |
| Explanation of any answers and additional evidence:   |             |

- We reviewed 3 recruitment files and found that appropriate recruitment checks had been carried out.

| <b>Safety systems and records</b>   | <b>Y/N/Partial</b> |
|---|--------------------|
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: 18/11/2022 | Y                  |
| There was a fire procedure.<br>Date of fire risk assessment: 15/07/2022   | Y                  |
| Actions from fire risk assessment were identified and completed.  | Y                  |

## **Infection prevention and control**

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

|  | <b>Y/N/Partial</b> |
|--|--------------------|
| Staff had received effective training on infection prevention and control.   | Y                  |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit: 22/11/2022   | 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>• Following the latest infection prevention and control audit an action plan was produced in order to improve standards. This included repairing a small split in a patient examination couch and a sharps bin that was not signed and dated. At the site visit, we found the actions on the action plan had been completed.</li> </ul> |                    |

## **Risks to patients**

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

|   | <b>Y/N/Partial</b> |
|---|--------------------|
| 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                  |

## **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. <sup>1</sup>                              | 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:   |             |
| <ul style="list-style-type: none"> <li>Review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.</li> </ul> |             |

## Appropriate and safe use of medicines

### The practice had systems for the appropriate and safe use of medicines, including medicines optimization but should improve the quality of medicine reviews.

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 average | 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) (NHS Business Service Authority - NHSBSA)   | 0.88     | 1.06          | 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)                                       | 7.4%     | 6.7%          | 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) | 4.81     | 4.66          | 5.28            | No statistical variation |

| Indicator   | Practice | SICBL average | England average | England comparison               |
|---|----------|---------------|-----------------|----------------------------------|
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>  | 126.6‰   | 265.9‰        | 128.0‰          | 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) <small>(NHSBSA)</small> | 0.13     | 0.42          | 0.58            | Significant Variation (positive) |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>   | 4.1‰     | 6.0‰          | 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.   | Partial     |
| 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.                  | 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. | 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           |

| Medicines management  | Y/N/Partial |
|---|-------------|
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.  | Y           |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.   | Y           |
| <p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li>• Our clinical searches highlighted 9 patients prescribed methotrexate (which is used to treat inflammatory conditions, including rheumatoid arthritis). Only 1 patient had not had the required monitoring. We looked in detail at this patient's record which showed they were under secondary care and there was evidence in the notes of monitoring. All patients had clear links in the records to shared care agreements (SCA), and it was clear from detailed medicine reviews that the SCAs were referred to as part of the routine review of patients on methotrexate.</li> <li>• We identified 13 patients out of 373 (3%) taking Angiotensin-2 receptor blockers (ARBs) or ACE inhibitors (ACEI) who were found to be out of date of routine blood monitoring, with no renal function check within 18 months. ARBs and ACEIs are medicine used to treat high blood pressure, heart failure, kidney disease and other conditions. We looked at 5 patients notes, only 1 had not had the required monitoring. All other patients had been identified and recalled for reviews. There were clear notes to show that the practice engaged with patients to ensure their monitoring was up to date.</li> <li>• Our clinical searches identified that 298 patients had had a medicine review in the last 3 months. We looked at 5 patients records, the quality of the medicine reviews were poor. There was no indication that medicine reviews had been conducted involving patient or carers with no notes to say that potential side effects had been discussed. During the site visit we were given evidence to show that the pharmacy team had been reviewing medicine reviews to ensure the expected quality was achieved.</li> </ul> |             |

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

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

| Significant events  | Y/N/Partial |
|---|-------------|
| The practice monitored and reviewed safety using information from a variety of sources.   | 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:  | 9           |
| Number of events that required action:  | 9           |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff questionnaires received by CQC highlighted that members of staff understood the process for raising and reporting incidents.</li> <li>• The practice had regular meetings where significant events were discussed and learning was shared.</li> </ul> |             |

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

| Event   | Specific action taken   |
|---|---|
| Emergency medication had not been checked which resulted with out of date medication on site.   | This was discussed at the nurse meeting to ensure the importance of checking this medication was understood. As a result of this significant event nurses were given dedicated time to check stock levels and expiry dates of emergency medication. |
| The practice missed a 2 week wait referral for a patient as the task was sent to the secretaries on a Friday evening before a bank holiday and was not completed until the following Tuesday. | All staff were reminded that the reception team have been trained to complete these tasks as well as secretaries. Staff now ensure they have completed urgent tasks before finishing work that day.   |

| 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           |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Our clinical searches identified patients taking SGLT-2 inhibitors (diabetes medicine) who had Fournier's gangrene (a necrotic infection) had been pro-actively contacted and advised of the risks of taking this type of medication. An additional search of patients of child-bearing age on teratogens showed that in all cases, patients had been pro-actively contacted about the risks of using their medication.</li> </ul> |             |

## Effective

## Rating: Good

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

### Effective needs assessment, care and treatment

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

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

### Effective care for the practice population

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

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice 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.
- Our clinical searches identified 63 patients as a potential missed diagnosis of chronic kidney disease (CKD). We looked at 5 patient records, 1 patient had a fluctuating estimated Glomerular Filtration Rate (eGFR) and did not have CKD. The other 4 patients all had either high frailty or in one case a terminal illness, and management of CKD would have been of little value.

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Our clinical searches identified 20 asthma patients out of 439 (8%) prescribed 2 or more courses of rescue steroids. Asthma reviews were done by a specialist nurse and found to be of high quality, incorporating inhaler technique checks and discussion of the asthma management plan.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Our clinical searches showed 17 patients out of 232 (7%) with diabetic retinopathy who's latest HbA1C was greater than 74. We reviewed 5 sets of notes, all had been identified and followed up appropriately with referrals as necessary to the community diabetic specialist team. Diabetic annual reviews had taken place for all patients and found to be of good quality, using templates to reflect evidence and NICE guidance.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--------------------|-----------|-------------|------------|---------------------------------|
|--------------------|-----------|-------------|------------|---------------------------------|



|   |    |    |        |                          |
|---|----|----|--------|--------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (UKHSA COVER team) | 54 | 54 | 100.0% | 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) (01/04/2020 to 31/03/2021) (UKHSA COVER team)  | 44 | 44 | 100.0% | Met 95% WHO based target |
| 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)  | 44 | 44 | 100.0% | Met 95% WHO based target |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team)   | 44 | 44 | 100.0% | Met 95% WHO based target |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team)  | 39 | 44 | 88.6%  | Below 90% minimum        |

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

### Any additional evidence or comments

- The practice had been working to improve the uptake of children aged 5 receiving immunisations for measles, mumps and rubella. This included nurses educating patients on the importance of having the immunisations. Nurses worked closely with local health visitors to encourage patients to receive their immunisations.
- The practice had also started working with local school nurses to capture patients who hadn't had their full set of vaccinations.
- The practice had a process in place then when a child did not attend 3 appointments for immunisations then the safeguarding team would be informed to ensure a safety netting for those patients.

| Cancer Indicators  | Practice | SICBL average | England average | England comparison       |
|--|----------|---------------|-----------------|--------------------------|
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency) | 67.0%    | N/A           | 80% Target      | Below 70% uptake         |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)   | 54.0%    | 63.6%         | 61.3%           | N/A                      |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)  | 69.0%    | 69.0%         | 66.8%           | N/A                      |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)  | 66.7%    | 60.7%         | 55.4%           | No statistical variation |

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.

| Any additional evidence or comments  |
|--|
| <ul style="list-style-type: none"> <li>The practice acknowledged that they needed to improve the coverage of cervical cancer screening.</li> <li>They had started offering extra appointments through the extended access scheme. Extended access is the offer, to registered patients of a practice, of pre-bookable appointments outside of core contractual hours, either in the early morning, evening or at weekends.</li> <li>We found that protected time slots had been built into nurse rotas that were to only be used for doing cervical cancer screening.</li> <li>The practice had created a large display in the waiting room of the practice which offered information to patients about the importance of screening with the aim of answering any questions and reassuring patients who were anxious.</li> <li>The practice provided unverified data which showed that cervical cancer screening for patients aged 25 to 49 was at 68.3% and patients aged 50 to 64 was at 78.7%.</li> </ul> |

### 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

|  |
|--|
| <p>The practice undertook a quality improvement audit into renal function of patients on direct-acting oral anticoagulants (DOACs) and to ensure patients were on the correct doses. DOACs are medicine used to prevent blood clots in patients. This was a 2 cycle audit and showed clear improvement in the second cycle.</p> <p>A clinical audit was also done monitoring patients on Lithium. We found a clear improvement for these patients, including improved use of shared care arrangements and liaison with specialists when required.</p> <p>The practice also completed a clinical audit looking at the quality of disease-modifying antirheumatic drugs (DMARDs) monitoring. DMARDs are medicine used commonly to treat people with rheumatoid arthritis. We saw that shared care arrangements had been achieved and correlated with our clinical searches findings.</p> |
|--|

### 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           |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had a structured induction system for all members of staff. Staff worked through this induction with support from managers and colleagues until they were deemed competent.</li> <li>Feedback from CQC staff questionnaires highlighted that members of staff had access to regular appraisals.</li> </ul> |             |

## Coordinating care and treatment

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

| Indicator   | Y/N/Partial |
|---|-------------|
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Y           |
| Patients received consistent, coordinated, person-centred care when they moved between services.                    | Y           |

## Helping patients to live healthier lives

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

|  | Y/N/Partial |
|--|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.  | Y           |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health.  | Y           |
| Patients had access to appropriate health assessments and checks.  | Y           |
| Staff discussed changes to care or treatment with patients and their carers as necessary.  | Y           |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.   | Y           |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice was involved in a number of initiatives, this included; a diabetes support group which was run by the practice with the aim of stopping patients being referred to secondary care. A specialist respiratory nurse came in every week to support patients who had COPD and other respiratory conditions.</li><li>• The practice also offered smoking cessation and weight management clinics.</li><li>• The practice had a wellbeing and wellness board in the waiting room, this had information about the cost of living, food banks and warm spaces for patients that were struggling with increased energy prices. The practice also had access to social prescribers.</li></ul> |             |

## Consent to care and treatment

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

|  | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | 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 |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We found that 36 patients had DNACPR decisions recorded in the last 12 months, due to the amount of patients registered at the practice this suggested a proactive approach to obtaining and recording end of life decisions. We looked at 3 patient's records, in all cases, the DNACPR decision was visible on the patient summary and alerts were present.</li> </ul> |   |

# Responsive

# Rating: Good

## Responding to and meeting people's needs

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

## 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 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           |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice offered a range of different appointments for patients, these included face to face, telephone and video consultations.</li><li>• The practice also offered appointments through the extended access scheme. Extended access is the offer, to registered patients of a practice, of pre-bookable appointments outside of core contractual hours, either in the early morning, evening or at weekends.</li><li>• Extended access appointments were available with a wide range of clinical staff.</li><li>• The practice had access to an interpreter service when needed if the patients first language was not English.</li></ul> |             |

## Well-led

Rating: Good

### Leadership capacity and capability

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

|   | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability.   | 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>• Leaders at the practice identified challenges and put in actions to mitigate these. This included educating patients on what services were available and ensuring that patients were getting the right appointments.</li><li>• Staff feedback received from questionnaires was overwhelmingly positive about how visible and approachable leaders were.</li><li>• The organisation had arrangements in place for succession planning,</li><li>• The practice had systems in place to allow staff to develop into new roles. An example shared through the inspection showed a member of staff who had started off working as part of the reception team who had been trained by the practice to become a health care assistant.</li><li>• The practice did not currently have a registered manager in place however they were in the process of applying to have one.</li></ul> |             |

### Vision and strategy

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

|   | Y/N/Partial |
|---|-------------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Y           |
| Staff knew and understood the vision, values and strategy and their role in achieving them.                 | Y           |
| Progress against delivery of the strategy was monitored.  | Y           |

### Culture

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

|  | Y/N/Partial |
|--|-------------|
|--|-------------|

|   |   |
|---|---|
| There were arrangements to deal with any behaviour inconsistent with the vision and values.   | Y |
| Staff reported that they felt able to raise concerns without fear of retribution.   | Y |
| There was a strong emphasis on the safety and well-being of staff.  | Y |
| There were systems to ensure compliance with the requirements of the duty of candour.   | Y |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action.   | Y |
| The practice encouraged candour, openness and honesty.  | Y |
| The practice had access to a Freedom to Speak Up Guardian.  | Y |
| Staff had undertaken equality and diversity training.   | Y |
| Explanation of any answers and additional evidence:   |   |
| <ul style="list-style-type: none"> <li>• Staff feedback received highlighted that staff felt comfortable to raise concerns. Staff were also able to identify who the practice's Freedom to Speak Up Guardian was.</li> <li>• The practice had initiatives to promote the well-being of their staff. This included, taking part in team building exercises and vouchers at Christmas as a reward for their hard work. They also organised regular social nights outside of work.</li> <li>• Staff members also had access to Occupational Health services when required.</li> <li>• It was evident when speaking to staff they felt well supported by the leadership team and would be happy to go to them if they required more support.</li> </ul> |   |

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

| Source  | Feedback   |
|---|--|
| CQC completed electronic staff questionnaires | The overwhelming majority of responses to the staff questionnaires we received described the practice as a "friendly" and "good" place to work. None of the questionnaires received had any negative comments about the culture of the organisation. |

#### Governance arrangements

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

|   | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed.               | Y           |
| Staff were clear about their roles and responsibilities.                                  | Y           |
| There were appropriate governance arrangements with third parties.                        | Y           |
| There are recovery plans in place to manage backlogs of activity and delays to treatment. | Y           |



## Managing risks, issues and performance

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

|   | Y/N/Partial |
|---|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved.  | Y           |
| There were processes to manage performance.   | Y           |
| There was a quality improvement programme in place.   | Y           |
| There were effective arrangements for identifying, managing and mitigating risks.   | Y           |
| A major incident plan was in place.   | Y           |
| Staff were trained in preparation for major incidents.  | Y           |
| When considering service developments or changes, the impact on quality and sustainability was assessed.  | Y           |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had a disaster recovery policy. This would be followed in the event of a major incident.</li><li>• If needed the practice were able to move staff around the different sites to provide resilience when required.</li><li>• The practice had recently changed their telephone system over to a cloud based system which allowed staff to work from home if required.</li></ul> |             |

## Appropriate and accurate information

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

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

## Governance and oversight of remote services

|   | Y/N/Partial |
|---|-------------|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y           |
| The provider was registered as a data controller with the Information Commissioner's Office.                                      | Y           |
| Patient records were held in line with guidance and requirements.   | Y           |
| Patients were informed and consent obtained if interactions were recorded.  | Y           |
| The practice ensured patients were informed how their records were stored and managed.  | Y           |
| 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           |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had recently started up its Patient Participation Group (PPG) again since the COVID 19 pandemic. Through this meeting they were able to effectively communicate with the group and inform them about new services that were available.</li> </ul> |             |

### Feedback from Patient Participation Group.

| Feedback  |
|---|
| We spoke with two members of the PPG, they told us: <ul style="list-style-type: none"> <li>That they felt positive about the practice going forward following the first meeting.</li> <li>Staff at the practice were amenable and good at introducing themselves and explaining their job roles.</li> </ul> |

## 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 identified that they did not have enough reception staff due to high staff turnover following the pandemic. They had been recruiting continuously to improve this so staffing levels would be maintained and not go below what was required again. We found that they now had a stable workforce in place. Through staff questionnaires received the majority were positive about their workload and that they felt supported by managers.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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