

## Inspection Evidence Table

Mather Avenue Surgery

(1-569823246)

Inspection Date: 24.10.23

**Overall rating: Good**

## Context

Information published by the Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the 4th lowest decile (4 out of 10). The lower the decile, the more deprived the practice population is relative to others. According to the latest available data, the ethnic make-up of the practice area is 3% Asian, 93% White, 4% Other.

At the time of inspection, the practice had experienced recent challenges with unexpected medical absence and recruitment of nurses. They had a number of vacancies which had recently been recruited to which included a health care assistant and a pharmacist. The leadership team were responsive to these challenges. Business plans were in place to identify and act on succession planning, risk assessments, team building, staff health and wellbeing, training, and other areas of work including access, prevalence and quality outcomes.

**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.	Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Not all staff were trained to the required levels. Nurses were only trained to level 2 and administration staff to level 1. However, this was an oversight on the part of the practice who had followed incorrect guidance. As soon as this was pointed out the appropriate level of training was arranged for all staff.</li> <li>• The safeguarding lead and other staff were able to demonstrate that discussions were held between other health and social care professionals in relation to safeguarding concerns and these were managed appropriately. We saw many examples of appropriate interventions and referral for safeguarding. However, we noted there was not a safeguarding register in place and meetings were not formally documented. The safeguarding lead said that this was something that had been done in the past but had been difficult to maintain due to lack of administration support. We were assured they would implement this immediately going forward.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We reviewed 5 personnel files and noted that the data kept in each file was inconsistent. We discussed our findings with the practice manager and immediately following the inspection received an action plan to ensure that all documentation for staff personnel would be consistent going forward.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment: 8.9.2023	Yes
There was a fire procedure.	Yes

Date of fire risk assessment: 6.9.2023	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>A full fire risk assessment and a full health and safety risk assessment were undertaken every two years by an independent company. Every alternate year there was a review of the previous assessment to ensure compliance was being maintained. We saw that all identified actions were either being or had already been completed.</li> </ul>	

### Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 2023	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The premises were clean and hygienic throughout.</li> <li>Infection control audits were undertaken on a regular basis.</li> <li>We checked the fridges which were well maintained and not overstocked.</li> <li>We spoke with a member of nursing staff who demonstrated the process to maintain the cold chain and what would be done if there was any breach.</li> <li>Actions were undertaken following the infection control visit where a score of 90% was achieved. Daily checks for cleanliness and control were undertaken, specimens were collected in a box with a lid, lids in toilets were placed on bins and defibrillator pads were suitable for both children and adult use.</li> </ul>	

### Risks to patients

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

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

The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice team including clinical and non-clinical staff was able to demonstrate fully on the morning of the inspection that they were equipped, trained appropriately and able to respond to medical emergencies.</li> <li>We reviewed the induction system for temporary and permanent staff and were satisfied that planned and unplanned leave was well managed.</li> </ul>	

### Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. <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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li><sup>1</sup> Review of patient records in relation to the clinical searches identified that care records were mostly managed in a way to protect patients. History, examination, management plans, safety netting and follow up were adequately documented within the patient record. Medication reviews were not always substantially documented as such. This was discussed with the practice during the inspection and was accepted as an area that could and would be improved going forward.</li> <li>It was identified that there was a large number of uncompleted tasks, some of which, according to the practice, needed to remain active as reminders or diary dates. We received assurance by way of an action plan immediately following the following the remote access and before the site visit, that this was being addressed. Going forward the practice planned to remove all old administration tasks such as old alerts raised during the pandemic. They also planned to do a random sample of 5 tasks every month to check they were being dealt with appropriately.</li> </ul>	

## 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) (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small>	0.70	0.95	0.91	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). (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small>	11.4%	7.4%	7.8%	Tending towards variation (negative)
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 (01/01/2023 to 30/06/2023) <small>(NHSBSA)</small>	5.62	5.41	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) <small>(NHSBSA)</small>	166.0‰	229.3‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small>	0.48	0.81	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) <small>(NHSBSA)</small>	10.5‰	11.1‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	NA
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. <sup>1</sup>	Yes

The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. <sup>2</sup>	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li>• <sup>1</sup>Medicine reviews. The provider recorded that medicine reviews had been conducted without documenting the outcomes from the review and without addressing required monitoring or changes to treatment that should have been identified during a comprehensive review. This was discussed with the practice during the inspection and was accepted as an area that could and would be improved going forward.</li> <li>• <sup>2</sup>With regards medicines that require monitoring and DMARD medicines the provider was able to demonstrate that it was safe to prescribe medicines to patients where specific, frequent, monitoring was required and no concerns were identified.</li> <li>• The provider was affiliated with a service that supported patients with drug addiction who were stable. A clinic was held at the practice to review these patients and manage their methadone programme and titration.</li> </ul>	

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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	8
Number of events that required action:	8
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>We reviewed significant incident reports and saw that these were documented and actioned consistently over a period of several years, recording the background, good practice identified, areas of concern, areas for review, suggestions to prevent recurrence, action to be taken and by whom and review.</li> </ul>	

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

Event	Specific action taken
A report was uploaded to an incorrect patient with similar name resulting in prescription being sent to the wrong patient.	The patient was contacted as soon as the error had been identified. Protocol ensured that date of birth is always checked and matched along with name as a point of identification. All pharmacy queries regarding prescription rejections were now reviewed by a GP.
A sharp kitchen knife was found by the cleaner in a waste bin.	All staff received up to date training on infection control inclusive of disposal of sharps. Refresher on waste disposal also circulated to staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>4</sup>	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li><sup>1</sup>The provider was unable to demonstrate that all relevant safety alerts had been responded to. We identified 5 patients on combinations of medicines that increased their risk of heart problems without anything in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered. The practice provided an action plan prior to the onsite inspection. We saw that the patients had been reviewed and that this would be monitored going forward.</li> </ul>	

# Effective

# Rating: Good

Put explanation here or right click and delete row

*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. <sup>1</sup>	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li><sup>1</sup>During the onsite inspection we discussed with clinical and non-clinical staff the way in which patients' needs and ongoing care were assessed, including their clinical, mental and physical wellbeing. Staff demonstrated how patients could be signposted to social prescribers and other first contact providers within the network for support. However, the clinical searches identified patients 4 out of 5 patients with hypothyroidism who were not appropriately recalled for blood test monitoring. The patients were discussed with the practice and all were reviewed prior to the onsite inspection. Ongoing action was completed to ensure that future thyroid function monitoring was added to the diary every 12 months or more often if clinically indicated.</li><li><sup>2</sup>We saw there was an appropriate system in place for onward referrals to secondary services including 2 week wait referrals and patients were followed up in a timely and appropriate way.</li><li><sup>3</sup>The clinical searches identified concerns that required review in areas such as potential missed diagnosis of diabetes. However, we saw from the action plan provided by the practice that all patients</li></ul>	



identified to them had been reviewed and any follow up had been actioned. This was also demonstrated during discussion at the onsite inspection.

## Effective care for the practice population

### Findings

- Patients 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.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered 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.

## Management of people with long term conditions

### Findings

Examples of other findings included:

- 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. Patients with chronic kidney disease were well managed.
- 1GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. Nurses we spoke with were able to demonstrate this and we saw certificates in place for health care assistants. However, out of 592 asthma patients 36 were found with 2 or more exacerbations in last 12 months. Out of 5 patients sampled 4 were found to have had no review. The practice had a system in place whereby all letters identifying an asthma hospital admission were notified to the practice nurse team who arranged follow up within 1-2 weeks. In addition, if a clinician prescribed oral steroids a flag appeared reminding the clinician to task the practice nurse team and arrange follow up. Of the patients highlighted as a concern, the practice was able to demonstrate that review had taken place for two of those patients and follow up processes initiated for the others. However, as part of the action plan the practice put further protocols in place to ensure this was better managed and that locum clinical staff were also made aware of the requirements.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training. Nurses we spoke with were able to demonstrate this and we saw certificates in place for health care assistants.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. We discussed this with the practice as they had a high prevalence of patients with lung diseases so did a lot of work around respiratory disorders. We saw evidence of two cycle respiratory audits and ongoing over years.
- 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.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	103	111	92.8%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	94	105	89.5%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	95	105	90.5%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	96	105	91.4%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	106	120	88.3%	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

Additional information relating to effective care for children and young people.

- We discussed the care of families who did not wish their children to be vaccinated. Appropriate steps were taken where possible to continue to send educational leaflets and requests for attendance.

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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) <small>(UKHSA)</small>	64.8%	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) <small>(UKHSA)</small>	70.6%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (3/31/2023 to 3/31/2023) <small>(UKHSA)</small>	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) (4/1/2021 to 3/31/2022) <small>(UKHSA)</small>	48.0%	49.9%	54.9%	No statistical variation

**Any additional evidence or comments**

The practice was aware of the lower than average results for immunisations and cervical screening and had programmes in place to improve these. We saw evidence of outstanding practice with events in place for hard to reach patients.

- The aim of the events was to promote health and awareness for cancer screening and vaccinations and immunisations in areas where patient engagement rates were lower. At the time of the inspection 3 events had taken place with a number of partner organisations in attendance also. Stalls were set up for each health promotion topic. The stall for cervical cytology was staffed by 2 nurses from the practice as well as 1 of the GPs in their role as Cancer Lead for the Primary Care Network (PCN). There was written information on cervical cytology including easy read information, cytology taking equipment on display and 2 models of female anatomy with a selection of educational cervixes.
- Attendees were asked if they were up to date with screening tests. If they were not sure staff were on hand to ring the patient's surgery to check dates and book a test with the patient's consent. Patients too young for screening were educated regarding what the test involved for the future. Information was available for non-English speaking patients via Jo's Trust including videos explaining what the test was about.
- Refugees from Afghanistan were in attendance and staff were able to speak about the importance of attending for tests. There was a community leader and an English teacher in attendance and a lot of productive time was spent with the group.
- A GP and nurse from the practice presented to Afghan refugee women at another event regarding what a cervical screening test is and what breast screening entails. Concerns and questions that they had were able to be addressed. An interpreter was present at the event. Since that event some of the women had come forward for cervical screening and also for mammograms – one breast cancer was picked up and was currently being followed up.

**Monitoring care and treatment**

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> <li>• We saw evidence that the practice had a quality improvement programme year on year and we reviewed several two-cycle audits that had taken place.</li> <li>• Examples of quality improvement included COPD in patients, prescription requests improvement, access, early cancer diagnosis, care of people with learning disabilities, improvement in uptake of screening programmes, patients on high doses of addictive medicines, 2ww referrals.</li> <li>• The practice also demonstrated ongoing review of each element of the key questions relating to good patient outcomes.</li> <li>• The practice had a programme to improve screening rates for people from different backgrounds. The practice had been observed whilst delivering education at community venues and had been approached to make an educational film that could be made available in surgery waiting rooms throughout the country.</li> <li>• Flexibility of appointment times was maintained by the practice and the practice had undertaken several reviews to ensure that patients were receiving an optimum service. Most recently a search was run for patients had had seen a GP 5 times or more in the previous 3 months. 56 patients were found. Patients identified had their notes reviewed by a nurse clinician. 7 patients were highlighted for further discussion, all other attendances were felt to be appropriate and necessary.</li> </ul>	

**Effective staffing**

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes

Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	NA
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice was able to demonstrate that staff undertook regular mandatory training and were also developed into other roles when requested. We saw evidence of staff progressing from apprenticeship to permanent reception/administration staff, receptionist/admin staff developed to health care assistants and phlebotomists and a health care assistant undertaking a practice nurse qualification. Progression training was funded by the practice.</li> <li>We identified that safeguarding training was not attained at the correct level for administration and nursing staff. This was due to the fact that the practice was following outdated guidance. This was pointed out during the inspection and an action plan put in place immediately for all staff to be trained to appropriate levels.</li> </ul>	

### Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice was able to demonstrate effective communication with other organisations such as the out of hours service, health visitors, charitable organisations, social prescribers and other voluntary organisations to ensure the best possible interventions for patients.</li> </ul>	

### Helping patients to live healthier lives

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

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

Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

### Consent to care and treatment

**The practice demonstrated that consent for care and treatment was sought in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li><sup>1</sup>The practice had an established process for DNACPR reviews. The PCN had won a bid and a member of the practice was clinical lead for the project which involved training up non-clinical staff to undertake effective cancer care reviews and also to buy IT specifically for cancer to provide reminders about care reviews and provide automatic safety alerts for 2 week-wait referrals. There was also a plan in place for safety netting of patients on DNACPR that did not have cancer or were not on the GSF register.</li> </ul>	

## Caring

**Rating: Good**

Put explanation here or right click and delete row

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes

Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
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Patient feedback	
Source	Feedback
NHS Choices	8 out of 11 reviews were positive about care and treatment at the practice.

### 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 (01/01/2023 to 30/04/2023)	87.3%	85.8%	85.0%	No statistical variation
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 (01/01/2023 to 30/04/2023)	87.5%	85.3%	83.8%	No statistical variation
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 (01/01/2023 to 30/04/2023)	92.2%	92.7%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	78.9%	70.1%	71.3%	No statistical variation

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

### 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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence:	

- Patients of the practice had access to a care co-ordinator and social prescriber through the primary care network. This service helped patients around finances, communication, personal, social and housing concerns or needs.
- Patients also had access to a befriending service available at a neighbouring GP practice.

### 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 (01/01/2023 to 30/04/2023)	91.8%	90.1%	90.3%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	428 patients were currently coded as carers which was 4.78% of current registered patients.
How the practice supported carers (including young carers).	A Carers register was in place and patients could be referred to Social Prescribers for help with their health and wellbeing if they wished. There was information on the practice website for patients to refer to.
How the practice supported recently bereaved patients.	The practice sent condolences cards and rang patients to offer more support if they wished it. There was information on the practice website for patients to refer to.

### 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.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

## Responsive

**Rating: Good**

Put explanation here or right click and delete row

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	Urgent appointments were available Monday to Friday by telephone between 8am and 6.30pm.  Patients could visit the surgery and speak to a receptionist between the hours of 8.30am and 6.30pm Monday to Friday excluding bank holidays.

	<p>Routine appointments could be booked over the telephone.</p> <p>Appointments were available in the form of face-to-face, telephone, video and text or email.</p> <p>Home visits were available on request if appropriate.</p>
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### 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 the community services to discuss and manage the needs of patients with complex medical issues.
- Nurse appointments were flexible to support children when necessary so they did not miss school.
- Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school.
- The practice held a register of patients living in vulnerable circumstances 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 who required extra help.

### Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Flexibility of appointment times was maintained by the practice and the practice had undertaken several reviews to ensure that patients were receiving an optimum service.</li> <li>• Reasonable adjustments had been made for people with a physical disability. Hearing loops were in place for people hard of hearing. Automatic doors were in place.</li> </ul>	

- The practice worked closely with the community learning disability team in enabling people with learning disabilities to access health care. An annual review of all patients with a learning disability was undertaken. The practice adjusted appointments for patients so that they had longer appointment times if desired.
- The practice was aware of patients who found it hard to access services, such as patients with mental health needs. They worked with a mental health liaison worker who attended the practice to review vulnerable patients.

### 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 (01/01/2023 to 30/04/2023)	69.6%	N/A	49.6%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	60.5%	50.7%	54.4%	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 (01/01/2023 to 30/04/2023)	52.0%	52.1%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	70.4%	72.3%	72.0%	No statistical variation

#### Explanation of any answers and additional evidence:

- Feedback was obtained from patients through friends and family results, inhouse patient survey and consistent audit and action of access.
- The practice had a continual evaluation plan to ensure patients were seen in a timely fashion and by the correct team member. To achieve this they employed care navigators, offered skill mixed appointments with additional roles and had a mixture of telephone, e-consultations and face to face appointments. Access was assessed on an annual basis to ensure patients had choice and that they were offered an appointment at first contact.
- Telephone access had been above the local and averages over time. In the last year there had been an upward trend of 4%.
- They were below the local and national levels between 2018 and 2021 for satisfaction of appointment times but had risen to local and national level in 2022/2023. Overall satisfaction of appointments remained static and below local and national level.
- Results for patient overall experience had been variable over the previous few years being above and below local and national data. In 2021/2022 there was a downward trend of 30% when the practice fell

below the local and national results. In 22/23 this went up by 16% and was now above local and national level.

Source	Feedback
NHS.uk website (formerly NHS Choices)	8 out of 11 responses were positive

### 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.	8
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<ul style="list-style-type: none"> <li>We saw that complaints were well managed and were a regular item on the agenda of all meetings.</li> <li>All staff were involved in the handling of complaints and information from complaints was used to improve and learn.</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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had continual evaluation plans in place and we reviewed the plan for 2023/2024 which looked at things like evaluation of the current position taking stock of where and how the practice could improve, ensuring the correct information was available for key people rather than relying on perception and supporting staff wellbeing.</li> <li>• Leaders were actively engaged in quality and operational sustainability and development, including working collaboratively with other agencies to develop services both nationally and across the local community. They recognised challenges and took action to address these, implementing innovations to improve care for their patient population. Staff consistently fed back that leaders were approachable and visible and that development opportunities were available.</li> <li>• We were told by one of the clinicians that the practice had always been supportive of the development of staff members. Examples included temporary staff recruited to support reception that had become permanent staff and then trained in the skills to become health care assistants before moving into nurse training.</li> <li>• A nurse associate programme was now completed and a nurse in the practice was training a new health care assistant who had joined the practice to support succession planning and impact and investment targets. A new practice nurse had been recruited.</li> <li>• They demonstrated values at the heart of all their decision making and when things were changing, they did so with the patient at the centre of their thinking to be as innovating, as patient led and as compassionate as possible.</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
<p>Explanation of any answers and additional evidence:</p>	

- The leaders were able to demonstrate that all the above was monitored regularly through surveys, clinical audits and staff and patient feedback.
- The practice ensured that staff were aware of their roles and that they were mentally and physically well enough to perform their roles in a supportive environment.

**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

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

Source	Feedback
Staff Surveys	Staff reported that the practice was a friendly, supportive and family like environment. Staff said they were trained well and supported to improve. Staff said they felt valued.

**Governance arrangements**

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Governance arrangements supported staff to deliver high quality care and treatment that was tailored to the needs of the local practice population. Arrangements included clear meeting and support structures that promoted accountability and effective communication. There were clear governance arrangements in relation to areas such as medicines management, service improvements, audit activity, non-medical prescribing, patient participation and quality improvement. These areas demonstrated that staff understood their responsibilities, that expectations were clear, and that there was a clear focus on improvement and ensuring the delivery of high quality services.</li> </ul>	

**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> <ul style="list-style-type: none"> <li>The practice had a comprehensive approach to assessing and implementing service developments. This included the use of quality improvement models that focused on the involvement of the wider practice team, to ensure that a range of views and initiatives were considered.</li> <li>A summary of quality improvement was in place including the improvement of cytology screening and cancer uptakes, respiratory improvement and better access for patients.</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

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had clear systems for learning and improvement, including reviewing processes when things went wrong or in response to patient complaints. Staff were involved in discussions about</li> </ul>	



learning and identifying areas and actions for improvement. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change.

- The practice closed for a half day each month to support staff on learning courses. This closure was supported by the primary care network and cover was provided to enable them to do this. Face to face courses and e-learning modules were available.
- Nurses attended Citywide and Locality nurse zoom and face to face meetings.
- There was regular communication with the local medical committee to keep the practice up to date with locality changes and improvements.

### Examples of continuous learning and improvement

- Staff wellbeing at all levels was very important to the practice. Since the pandemic, all staff had been affected and morale had been at an all time low. In order to improve wellbeing staff new staff had been recruited and existing staff had received an uplift to their salary.
- The practice demonstrated an ethos to ensure that staff remained well and happy in their employment so they could offer appropriate care and services to their patient population. In order to support this further an away day was agreed. This took place at an outside venue (a charitable organisation so that the charity would benefit as well). A motivational speaker was invited. Lunch was provided and all staff members were in attendance. This was to help staff understand how much they were valued, to increase moral and to help staff to understand their own self-worth and how important they were to their employers and to the community they served.

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$

No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥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 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 those aged 25 to 49, and within 5.5 years for those 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.