

Care Quality Commission

Inspection Evidence Table

Laburnum Health Centre (1-559160107)

Inspection date: 27 July and 17 August 2022

Date of data download: 21 July 2022

Overall rating: Requirement Improvement

Safe

Rating: Requires improvement.

- We have rated the practice as requires improvement for providing a safe service because the systems to assess, monitor and manage, safeguarding, medicines, risks to patient safety, significant events and information to deliver safe care and treatment were not always effective.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse, but they were not always fully effective.

| Safeguarding | Y/N/Partial |
|--|-------------|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | N |
| 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. | Partial |
| There were systems to identify vulnerable patients on record. | Partial |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Y |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none">Safeguarding systems, processes and practices were not always developed, implemented and communicated to staff. Whilst we observed child and adult safeguarding protocols displayed in clinical and administration rooms, the adult safeguarding policy provided by the practice did not contain sufficient information to ensure patient safety. We found the policy did not provide any information for non-clinical staff in relation to how to recognise and escalate patients | |

| Safeguarding | Y/N/Partial |
|--|-------------|
| <p>presenting to the practice showing signs of abuse. There was also no information provided regarding female genitalia mutilation (FGM) despite reporting they had patients who fit within these criteria registered with the practice.</p> <ul style="list-style-type: none"> The adult safeguarding policy did not provide any information relation to maintaining a safeguarding register and how often these patients would be reviewed, despite the practice stating there was a safeguarding register in place. In addition, no information was provided within the policy on how to code these patients on the clinical system in order to ensure they were not omitted from monitoring. The practice told us the safeguarding policies were reviewed every two years but evidence we found shows the child protection policy had not been reviewed for a considerable amount of time as it contained out of date information. For example, it referred to the local Primary care trust (PCT) which was discontinued nine years ago and replaced with the CCG. The policy referred to outdated guidance from 2006, with no reference to the 2019 child safeguarding intercollegiate document which contained updated guidelines on child protection. The policy also contained outdated training frequency as every two years, instead of three years as per the new guidance. The practice told us summary care records were available for the out of hours to access patient details, but relevant safeguarding information was not shared with them. We saw that there were vulnerable patient alerts on the system and the practice told us a safeguarding register was in place. We were provided with information to demonstrate all staff had completed both adult and children's safeguarding; however, the information did not state whether they had completed the appropriate level. The practice told us staff were trained to chaperone; training records showed some staff had received this training in 2016. | |

| 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. | N |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There were gaps in staff immunisation records. The practice provided some immunisation records for staff but record some were missing for both clinical and non-clinical staff. | |

| Safety systems and records | Y/N/Partial |
|--|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 13 January 2022 | Y |
| There was a fire procedure. | Y |
| Date of fire risk assessment: April 2022 Actions from fire risk assessment were identified and completed. | Y |

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

| | Y/N/Partial |
|--|-------------|
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: June 2022. | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | N |
| 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">• Not all staff could locate an infection control policy in the practice.• The infection control measures in the practice were ineffective as they did not adhere to the infection prevention and control national guidelines. We observed curtains in 10 clinical rooms were not disposable curtains and there was no evidence provided to show when they were last cleaned. We also found the cleaning mops in place were not disposable.• There were no sharps injury posters displayed in the clinical rooms.• The practice had carried out their own infection control assessment in June 2022, which identified cluttered rooms and the requirement for disposable curtains in consultation rooms. We observed clutter in five clinical rooms on the day of inspection.• Following the inspection, the practice provided evidence a formal audit that had been carried out in August 2022 which identified several issues with recommendations. | |

Risks to patients

The systems to assess, monitor and manage risks to patient safety were not always effective.

| | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods. | N |
| 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. | N |
| 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 | N |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The approach to manage staff absences and busy periods was inadequate. There were not enough clinical staff and there was no cover for absences. The practice also told us they did not consistently use regular locum GPs. Staff told us that when GPs were absent or on leave, there was no locum GP cover. This had an impact on patient care as they could not access GP care during absences. | |

- We also found there was no clinical cover on Thursday afternoons from 1pm when there were no clinics, but the practice doors were still open for patients. This had an impact on patient safety as the arrangements in the event of an emergency were unsafe. One staff member gave us an example of when they were approached by a patient who had behaviors of concern one afternoon when there was no clinician onsite and had to seek shelter in order to remain safe. There was no evidence following this incident that the practice had taken steps to prevent a recurrence.
- Following the inspection, the provider submitted information to explain that two practice nurses and two doctors had left the practice in 2021 and in 2022 the practice had been active in recruitment and had secured two practice nurses and two GPs. They hoped this would enable them to manage absences better. In addition, the practice had been tried to employ additional pharmacists, but this was difficult as the supply of additional pharmacy locally was limited. The practice was working actively with the Primary Care Network (PCN) clinical director to increase the pharmacist hours that were employed through the PCN.
- Some areas of the practice were not equipped to respond to medical emergencies. For example, the clinical room used for phlebotomy did not have a couch inside it due to the small size of the room. We also observed that this room did not have an appropriate phlebotomy chair to assist with patients who needed to sit down following blood tests. This meant patients would not have suitable equipment to assist them in the event of an emergency following blood tests.
- We were not assured reception staff were trained on sepsis awareness. Staff we spoke to were not aware of this and could not identify sepsis red-flag symptoms.
- The practice told us there was a medical emergency policy in place. We also viewed an anaphylaxis protocol sheet which contained out of date information.
- Staff told us there was not enough clinical staff to provide appointments. There was one pharmacist and the equivalent of one full-time nurse equivalent for over 9,000 patients.

Information to deliver safe care and treatment

Staff did not always have 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. | Partial |
| 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. | N |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Partial |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • We were not assured that staff always kept patient information secure. We observed some staff did not lock their rooms when leaving them. | |

- Coding in the patient records system, to easily identify issues, were not always accurate on patient records. For example, for one patient it was unclear why they were on medication.
- The practice participated in the summary care records initiative patients care summaries such as, medications, allergies and adverse reaction to medicines were shared with secondary care which included out of hours, walk-in centres and accident and emergency.
- A review of patient records found there were gaps in systems to share information with staff and other agencies to enable them to deliver safe care and treatment. We found one patient had not received a blood test to monitor their vitamin D levels despite a request from February 2022. We also found another patient had not received a repeat blood test as requested in their medical notes in October 2021.
- There were gaps in the systems for referrals to other services, including urgent referrals. The practice told us designated staff carried out two-week wait referrals and an audit was kept of these referrals. However, there was no system for the practice to supervise and monitor that these referrals were carried out safely. When we reviewed the two-week wait referral system for the last year, we found gaps in monitoring in each of the months we reviewed. For example, there was no outcome of referral recorded in eight of the referrals made in June 2022 and there was no evidence this process was being monitored by senior staff to ensure patients urgently referred were receiving their appointments.

Appropriate and safe use of medicines


The practice did not always have systems for the appropriate and safe use of medicines, including medicines optimisation

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA) | 0.64 | 0.60 | 0.79 | 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). (01/04/2021 to 31/03/2022) (NHSBSA) | 7.5% | 9.6% | 8.8% | 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 (01/10/2021 to 31/03/2022) (NHSBSA) | 5.50 | 5.74 | 5.29 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA) | 101.8‰ | 64.5‰ | 128.2‰ | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA) | 0.61 | 0.47 | 0.60 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA) | 10.4‰ | 5.4‰ | 6.8‰ | No statistical variation |

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

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Y |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | N |
| 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. | N |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured 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. | N |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | N |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. | N |
| 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. | N |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |

| Medicines management | Y/N/Partial |
|--|-------------|
| 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:</p> <ul style="list-style-type: none"> Although blank prescriptions were stored in locked rooms, they were not securely stored and there was no system in place to log the serial numbers of prescription pads, including when issues to individual prescribers or consulting rooms. Whilst there was a process for the safe handling of requests for repeat medicines, we found the process for carrying out medication reviews for patients on repeat medicines was not adequate. We reviewed five patient records and found it was not clear if the medication reviews were carried out with the patient. When we looked at other patient records, we found nine examples of overdue medication reviews dating from April and June 2018 for patients diagnosed with long term conditions. At the time of the inspection, we were not assured that the practice could demonstrate the prescribing competence of non-medical prescribers and regular review of their prescribing practice supported by clinical supervision or peer review. We found a prescribing error where a long-term prescription of Vitamin D since 2019 had led a patient to be admitted into hospital. Although this incident was raised as a significant event and clinicians were advised to be alert to what drugs should not be placed on repeat, there was no evidence of what safety netting the practice had put in place to ensure prescribers were following guidelines. We saw evidence where the practice participated in a presentation on antibiotic prescribing; however, some prescribing clinicians were unable to describe the practice's system for monitoring the prescribing of antimicrobials. Whilst the practice had processes in place for the monitoring of high-risk medicines such as leflunomide (used for relieving symptoms caused by active rheumatoid arthritis, such as inflammation, swelling, stiffness, and joint pain). We found the processes for monitoring patients prescribed other high-risk medicines such as Methotrexate, Lithium, Amiodarone and Warfarin was inadequate. There was no documented protocol in place for high-risk medicines. When we searched for patients prescribed methotrexate (used for reducing the inflammation that causes swollen and stiff joints in rheumatoid arthritis, thickened skin in psoriasis or damage to your bowel in Crohn's disease) on 25 May 2022, the search identified 19 patients were prescribed methotrexate and we found one of these patients was overdue the required monitoring of every three months. This patient was last monitored in January 2022 and the blood tests were three months overdue. The practice told us this patient was sent a reminder to attend for a blood test twice in June 2022 but this was still overdue and there was no evidence of any escalation process during that period. We found three of 11 patients prescribed azathioprine (used for rheumatoid arthritis. Crohn's disease and ulcerative colitis. severe inflammation of the liver, skin or arteries) had not received the required monitoring of every three months. For example, one patient last had their blood test monitoring for this medicine in October 2020, two years overdue. We found three of four patients prescribed lithium (used to treat mood disorders) had not received the required monitoring of every three months. We also found one patient, the practice had been advised to discontinue prescribing them lithium in June 2022; however, on inspection we found they continued to be prescribed this medicine which continued to be on their repeat medication list. The provider has responded that they will follow this up.  We found five of 18 patients prescribed spironolactone (used to treat high blood pressure (hypertension) and heart failure) had overdue blood tests. For example, one patient last received | |

| Medicines management | Y/N/Partial |
|--|-------------|
| <p>their blood test monitoring in June 2018, four years overdue instead of every six months as per recommended guidelines. The provider explained that they had reviewed these findings and believed they were due to a coding error on the patient record system which they would follow up. However, this demonstrated the monitoring of spironolactone was sometimes ineffective.</p> <ul style="list-style-type: none"> • When we looked at patients overprescribed asthma inhalers, we found 43 patients had been overprescribed inhalers. Two of these patients were overdue asthma reviews which were last carried out between December 2019 and November 2020. • We also found 17 patients prescribed ace inhibitors (used for) and spironolactone. Concomitant use of these two medicines increased risk of severe hyperkalaemia (meaning). We reviewed five patient records and found they had not been made aware of the risk of these two medicines • There were no systems to monitor the prescribing of controlled drugs. For example, the practice told us they did not review the prescribing of controlled drugs and there was no evidence of any arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. A prescribing policy was not provided on request. • The practice told us they carried out remote or online prescribing but there was no evidence of any effective systems in place to identify and verify the patient. | |

Track record on safety and lessons learned and improvements made

The practice had a system to learn and make improvements when things went wrong.

| Significant events | Y/N/Partial |
|---|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | N |
| 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. | Partial |
| Number of events recorded in last 12 months: | 5 |
| Number of events that required action: | 5 |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We were not assured the practice monitored and reviewed safety using information from a variety of sources. We found the significant events identified did not include where they related to patients whose had behaviors of concern in the practice. We found these incidents were not monitored or identified as significant events. Staff described several incidents where they dealt with patients with behaviors of concern, however, these were not recorded as such and staff told us they did not feel safe. Therefore, there was no learning or appropriate action taken to safeguard staff in relation to patients with behaviors of concern presenting at the patients. • We saw that recorded significant events were discussed in meetings and in some cases, we saw evidence where they were discussed with staff directly involved in the incidents. However, it was not clear how learning and dissemination of information occurred for staff who were not present at the meetings. | |

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

| Event | Specific action taken |
|--|---|
| Prescribing error which led to patient hospital admission for hypercalcemia, after they were prescribed a high dose of vitamin D on a long-term repeat prescription for the last three years. This was against prescribing guidelines. | The practice policy was reviewed, and clinicians and prescription clerks were made aware that high dose vitamin D should not be prescribed on a long-term basis. Action taken was to prescribe a weekly supply and the practice manager would carry out a patient record search to ensure there were no other patients affected. It was not clear what safety netting was put in place to ensure this would not occur again. |

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | N |
| Staff understood how to deal with alerts. | N |

Explanation of any answers and additional evidence:

- There was no system to identify patients prescribed combination drugs such as, amlodipine (used to treat high blood pressure) and simvastatin (used to treat high cholesterol). There was no action on the MHRA drug safety update in December 2014 that advised if patients were prescribed a high dose of both simvastatin and amlodipine, there was an increased risk of muscle damage and they should not be prescribed this. The alert advised that alternative statins should be prescribed but if simvastatin was the only option, the maximum dose was to be 20mg if prescribed with amlodipine. When we carried out a search to identify patients prescribed these combination drugs, we found 21 patients were affected by this alert and when we reviewed five of these patient records, we found there was no advice given in relation to the risk of myopathy interaction between both drug combinations to these patients. We also found these patients were also prescribed an incorrect dose of Simvastatin 40mg instead of maximum of 20mg as per the safety alert. The incidence of myopathy increased when simvastatin 40 mg was administered with amlodipine.

Effective

Rating: Requires Improvement

We rated the practice Inadequate for providing effective services because:

- Patients' needs were not always assessed and care and treatment was not always delivered in line with current legislation.

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 not always assessed and care and treatment was not always 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. | Partial |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Partial |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | N |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Y |
| Patients' treatment was regularly reviewed and updated. | N |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Partial |
| 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 | N/A |

Explanation of any answers and additional evidence:

- Although the practice had systems and processes to keep clinicians up to date with current evidence-based practice through clinical meetings, we were not provided with clinical meeting minutes to demonstrate this. We were not assured of a sharing process in place when a clinician was unable to attend clinical meetings.
- We were not assured that patients' immediate and ongoing needs were always fully assessed. For example, we found three patients with a potential missed diagnosis of diabetes and one of these patients was not receiving regular follow ups.

- There were no effective systems in place to ensure patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. Whilst there was a referral process in place and we saw evidence of some referrals and examples of shared care protocols with secondary care, we were not assured that this system was operating effectively to ensure there were no gaps in the referral pathway process. For example, we found one patient whose specialist advised the practice to refer them to occupational therapy in March 2022 but there was no evidence to show the practice had acted on this referral.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks were offered to patients over 75 years of age.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients with a learning disability were offered an annual health check. One of the GP partners carried out joint learning disability review clinics with the healthcare assistant. The practice told us that 89% of the 39 patients diagnosed with learning disability had reviews carried out in the past year.
- The practice did not have a up to date palliative care register put in place to ensure effective monitoring of these patients.
- We found practice gaps in the processes for assessing and monitoring the physical health of people with mental illness. We saw two examples where patients prescribed medication for their mental health illness did not have their weight monitored as per recommendations and when they had their last blood test monitoring carried out.
- Patients with poor mental health, including dementia, were referred to appropriate services. We saw examples where a junior clinician referred a patient with memory issues to the GPs to review.

Management of people with long term conditions

Findings

- When we carried out the inspection, we reviewed a sample of over 200 patient records within chronic disease groups and found examples where patients' care was not regularly reviewed and there was no effective recall system in place. For Example:-
 - On inspection we found two patients were overdue their diabetes monitoring since 2020. One patient was overdue their hypertension monitoring.
 - There was overdue chronic disease monitoring and we found that the practice was not monitoring all patients with pre-diabetes, hyperthyroidism and managing the risks associated with this was not clear.
 - Patients' treatment was not regularly reviewed and updated. For example, when we found one patients diagnosed with chronic kidney disease (CKD) stage 4 or 5 two patients had not received up to date blood test monitoring since 2019. The process to follow up these patients was not clear.

- We found one patient with hypertension and diabetes had not been reviewed since January 2020 and another patient diagnosed with hypertension had not had their blood pressure checked since January 2021.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 97 | 118 | 82.2% | Below 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 110 | 125 | 88.0% | 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 109 | 125 | 87.2% | Below 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 109 | 125 | 87.2% | Below 90% minimum |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 118 | 163 | 72.4% | Below 80% uptake |

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

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------|
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged | 58.5% | N/A | 80% Target | Below 70% uptake |

| | | | | |
|---|-------|-------|-------|--------------------------|
| 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency) | | | | |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA) | 52.6% | 54.8% | 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) | 55.4% | 58.1% | 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) | 52.0% | 53.2% | 55.4% | No statistical variation |

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

| | 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. | Partial |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | N |

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

- The practice was a training practice, carrying out postgraduate and undergraduate training.
- The practice had three GP trainers in the practice.
- The practice used a computer software program to monitor their delivery of care and treatment at the practice.

Any additional evidence or comments

- There were no systems in place to review unplanned admissions. The practice told us they did not automatically call patients for a review if they had been discharged from hospital. This was consistent with our observations on inspection where staff were unable to find any information relating to following up children who attended accident and emergency.

Effective staffing

The practice was not always able to demonstrate that some 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. | Not inspected |
| 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. | N |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Not inspected |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff generally had the skills, knowledge and experience to deliver effective care, support and treatment. The practice told us appraisals were carried out in the practice and provided us with a list of staff names and appraisal dates. At the time of the inspection, the practice could not demonstrate how they assured the competence of clinical staff such as nurses. They did not keep a copy of revalidation or continuing professional development training for nurses. The practice submitted a copy of clinical staff supervision of patient consultations for July 2022 only this covered all clinical staff. | |

Consent to care and treatment

| | Y/N/Partial |
|---|---------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Not inspected |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Not inspected |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a DNACPR system in place; however, when we carried out searches on the system, it showed no patients were under a DNACPR plan. Following the inspection, the practice provided evidence to show that 48 patients were under a DNACPR plan. | |

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

| | Y/N/Partial |
|---|---------------|
| Staff understood and respected the personal, cultural, social and religious needs of patients. | Y |
| Staff displayed understanding and a non-judgmental attitude towards patients. | Y |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Not inspected |

| Patient feedback | |
|---|---|
| Source | Feedback |
| Friends & Family results for the month of July 2022, 35 patients responded. | <p>When asked how likely are you to recommend our GP practice to friends and family if they need similar care or treatment? Patients responded: -</p> <ul style="list-style-type: none"> Extremely likely stated 40%, Likely stated 26%, Neither likely or unlikely stated 9%, Unlikely stated 8%, Extremely unlikely stated 14%, Don't know stated 3%. |

National GP Patient Survey results

| Indicator | Practice | CCG average | England average | 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 (01/01/2021 to 31/03/2021) | 83.5% | 85.0% | 89.4% | 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 (01/01/2021 to 31/03/2021) | 85.3% | 82.8% | 88.4% | 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 (01/01/2021 to 31/03/2021) | 92.6% | 92.8% | 95.6% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|----------------------|
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021) | 64.9% | 77.0% | 83.0% | Variation (negative) |

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

| Any additional evidence |
|---|
| <ul style="list-style-type: none"> The practice carried out a friends and family test survey which was completed by 35 patients. The results showed 23 of those patients were extremely likely and likely to recommend the practice to their friends and families. We saw information that encouraged feedback displayed in the practice. |

Involvement in decisions about care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Y |
| Staff helped patients and their carers find further information and access community and advocacy services. | Y |

National GP Patient Survey results

| Indicator | Practice | CCG average | England average | 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 (01/01/2021 to 31/03/2021) | 85.9% | 88.8% | 92.9% | Tending towards variation (negative) |

| | Y/N/Partial |
|---|-------------|
| Interpretation services were available for patients who did not have English as a first language. | Y |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Y |

| | |
|---|---|
| Information leaflets were available in other languages and in easy read format. | Y |
| Information about support groups was available on the practice website. | Y |

| Carers | Narrative |
|---|--|
| Percentage and number of carers identified. | 120 (1.3% of practice population) carers were registered with the practice. |
| How the practice supported carers (including young carers). | Carers were sent out local carers support link and we saw carers information displayed in the practice. |
| How the practice supported recently bereaved patients. | We saw bereavement posters displayed in the reception, however the practice told us although there was no current support in place; they were planning on sending letters to families with information regarding local support groups. |

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Requires Improvement

At our previous inspection in April 2022, we rated the practice as **requires improvement** for providing responsive services because:

- Although the practice had sought to improve access by adding two additional telephone lines and making changes to its appointment system, evidence from patient survey results and patient feedback relating to access continued to show patients were still unable to always access care and treatment in a timely way.
- The practice's 2021 GP Patient Survey results remained below national averages for most of the questions relating to access.
- Despite a slight improvement to the data relating to telephone access, this was still significantly below national average and consistent with patient complaints. Patient complaints received by CQC were in relation to access to the service.
- We were not assured the system in place for undertaking home visits was operating effectively.
- Complaints were not always used to improve the quality of care.

At this inspection, we have now rated the practice as Inadequate for providing responsive services because:

- Services continued not to meet all of the patient's access needs.

Responding to and meeting people's needs

Services did not always meet patients' needs.

| | Y/N/Partial |
|--|---------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | N |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | N |
| The facilities and premises were appropriate for the services being delivered. | Partial |
| The practice made reasonable adjustments when patients found it hard to access services. | Partial |
| There were arrangements in place for people who need translation services. | Y |
| The practice complied with the Accessible Information Standard. | Not inspected |

Explanation of any answers and additional evidence:

- The results of the GP survey and patient feedback demonstrated the practice was not meeting the needs of the population group.
- The practice had disabled facilities which included wheelchair access and a disabled toilet. However, there was no hearing loop in the practice to aid those with a hearing difficulty. They told us communication was via notepad.

- The clinical room used for phlebotomy did not have a couch inside it due to the small size of the room. However, there was also no appropriate phlebotomy chair to assist with patients who needed to sit down following blood tests.
- There was no support for carers or learning disability patients. They were not offered priority appointments or longer appointments.

| Practice Opening Times | |
|--|---------------------------------------|
| Day | Time |
| Opening times: | |
| Monday | 08.00am – 7.15pm |
| Tuesday | 08.00am – 7.15pm |
| Wednesday | 08.00am – 6.30pm |
| Thursday | 08.00am – 6.30pm |
| Friday | 08.00am – 7.15pm |
| | |
| Doctors Appointments available: | |
| Monday | 09.00am – 12.00pm and 4.00pm – 7.00pm |
| Tuesday | 09.00am – 12.00pm and 4.00pm – 7.00pm |
| Wednesday | 09.00am – 12.00pm and 4.00pm – 6.30pm |
| Thursday | 09.00am – 12.00pm only |
| Friday | 09.00am – 12.00pm and 4.00pm – 7.00pm |
| | |

| Further information about how the practice is responding to the needs of their population | |
|--|--|
| <ul style="list-style-type: none"> • In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred. • There was a medicines delivery service for housebound patients. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. | |

Access to the service

People were not able to access care and treatment in a timely way.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

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 | N |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online) | Partial |
| Patients were able to make appointments in a way which met their needs | N |
| There were systems in place to support patients who face communication barriers to access treatment | N |
| Patients with most urgent needs had their care and treatment prioritised | N |
| 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:

- Patients did not have timely access to appointments and patients with the most urgent needs did not have their care prioritised. As a result, we found significant gaps in the care of patients with chronic disease where they were not being monitored effectively. We also found patients with the most urgent needs were unable to access the practice via telephone when they called. Online reviews reported patients attempting to ring the practice for three months without success.
- We also found the practice had no clinical staff available onsite from 1pm until the start of the next doctors' clinics at 3.30pm and this was recorded inside the patient leaflet. They stated during this time the practice was open for general enquiries only; however, this meant in the event of a clinical emergency patients were placed at risk of harm due to the lack of a clinician onsite.
- Despite the practice telling us that they offered a wide range of appointments, patients often faced significant barriers accessing these appointments and were unable to make appointments which met their needs.
- Patients were not able to make appointments in a way that met their needs. One patient we spoke to on the day of inspection told us they rung the practice over 100 times to get access into the practice. There was no call waiting facility within the practice and this was consistent with staff reports.
- The systems in place to support patients who face communication barriers to access treatment were not responsive. We found patients were discouraged from walk-in appointment requests.
- The provider sent information following the inspection that the practice had participated in the local commissioning groups 'Access CI scheme' over the last 3yrs and had provided the appointments that it has been required to by the standards set in the scheme.

National GP Patient Survey results

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|----------------------|
| The percentage of respondents to the GP patient survey who responded positively to | 43.4% | N/A | 67.6% | Variation (negative) |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------------------|
| how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021) | | | | |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021) | 49.3% | 65.8% | 70.6% | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021) | 55.2% | 64.4% | 67.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021) | 68.9% | 76.3% | 81.7% | Tending towards variation (negative) |

Any additional evidence or comments

- At the time of the inspection we were not assured the practice was taking effective or urgent action to resolve their access issues. The practice had been rated requires improvement on three occasions for providing a responsive service, mainly in relation to poor access for patients. In addition. The two practice meeting minutes we reviewed for June and July 2022 did not discuss how access could be improved for patients.
- Following the inspection, the provider submitted information about how they planned to improve access. For example: -
 - Appointment of the fourth GP.
 - Changing the messaging service so that 111 was de-prioritised.
 - Greater use of the pharmacy referral scheme.
 - Meetings with the primary care network clinical director to increase the staffing numbers using the Additional Roles Reimbursement Scheme (ARRS)
 - More education for reception staff for triaging patient appropriately and escalating at risk patients to duty doctor.

| Source | Feedback |
|-------------------------|--|
| NHS Choices | The practice had received eight reviews where patients described the service as 'horrible'. Some reported unsuccessfully attempting to book an appointment and calling over 100 times only to be told appointments are fully booked. |
| Google reviews | The practice received a 1.5-star rating out of 106 reviews posted. People reported frustration at not being allowed to walk-in for appointments and some stated they were deregistering from the practice due to being unable to access them. Some reviewers stated they had failed to access appointments for the past three months and described the service as 'bad'. |
| Interview with patients | We spoke with two patients on inspection who told us it was incredibly difficult and found it frustrating to try obtaining an appointment at the practice. They told us they unsuccessfully attempted to contact the practice over 100 times and the |

| | |
|--|---|
| | only reason they attended the practice on the day of inspection was due to a call they received for an appointment, rather than through their own attempts to reach the practice. |
|--|---|

Listening and learning from concerns and complaints

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

| Complaints | |
|--|---|
| Number of complaints received in the last year. | 6 |
| 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 |

Explanation of any answers and additional evidence:

- The practice told us that since the last inspection, complaints were now discussed in meetings and patients were informed of actions taken.
- The practice told us the complaints received were access related complaints.
- The practice had a complaints policy in place for staff to follow, last reviewed in December 2021, this stated the manager and assistant practice manager were responsible for ensuring action was taken as a result of a complaint.

Well-led

Rating: Requires Improvement

We rated the practice requires improvement for providing well-led services because:

- There was no emphasis on the safety and wellbeing of staff.
- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- The overall governance arrangements were sometimes ineffective.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

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

Explanation of any answers and additional evidence:

- Whilst leaders demonstrated they understood the challenges to quality and sustainability, we were not assured they were taking the necessary actions to address these challenges. The practice had been rated requires improvement on three occasions in relation to patient access to the service. The practice agreed they were understaffed and told us this was as a result of a lack of support and inappropriate allocation of Primary Care Network (PCN) resources by the PCN director that hindered them from recruiting the necessary support staff. We also found the lead GP did not recruit locums to cover them for absences and as a result, patients were not seen, affecting their access to safe care and treatment.
- Staff told us leaders were not always visible or approachable. They felt a disconnect with leadership exacerbated by the distance between their offices, where frontline staff were based.
- This was consistent with our findings of absent leadership from the lead GP which led to a significant lack of clinical oversight of the activities occurring in the practice and affecting their ability to provide safe systems and processes.

Vision and strategy

The practice did not have a clear vision that was not supported by a 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. | N |

| | |
|---|---|
| Staff knew and understood the vision, values and strategy and their role in achieving them. | N |
| Progress against delivery of the strategy was monitored. | N |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice told us they had a clear view and strategy for the future, and they aspired to deliver high-quality care, but the lack of adequate clinical leadership had resulted in ineffective and unsustainable systems to deliver and monitor it. | |

Culture

The practice culture did not effectively support high quality sustainable care.

| | Y/N/Partial |
|---|---------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | N |
| Staff reported that they felt able to raise concerns without fear of retribution. | N |
| There was a strong emphasis on the safety and well-being of staff. | N |
| There were systems to ensure compliance with the requirements of the duty of candour. | Not Inspected |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | Not Inspected |
| The practice encouraged candour, openness and honesty. | Not Inspected |
| 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"> Whilst some staff felt they were able to escalate concerns; we were not assured this applied to all staff. We received concerns in relation to the GP's attitude towards staff and where they felt unsupported. We found there was no emphasis on the safety and wellbeing of staff and there was no policy in place to deal with behaviors of concern towards staff. For example, staff felt when dealing with patients' behaviors of concern in the practice, senior management did not attend to the incidents to provide them with support despite being present when the incidents occurred. Staff also felt repeated requests to take action to reduce the escalating daily incidents of aggression and verbal abuse towards frontline staff was not acted on. We were told this had an impact on local staff when confronted with patients with behaviors of concern outside practice premises. Staff also reported incidents of patient's behaviors of concern approaching them in the practice one afternoon when there was no clinician onsite. Staff told us they were forced to seek shelter inside the reception area in order to remain safe. There was no evidence following this incident that the practice had taken steps to prevent a recurrence. We found senior leaders were often too far away from frontline staff causing a disconnect where staff did not feel supported and despite being notified of these incidents by staff, this was not raised a significant event to ensure learning was shared and improvements made to the safety and wellbeing of staff. We | |

also observed a lack of security when walking into the building as it was difficult for staff to monitor who walked into the building.

- There was no evidence staff had access to an occupational health service.

Governance arrangements

The overall governance arrangements were sometimes ineffective.

| | Y/N/Partial |
|--|-------------|
| There were governance structures and systems which were regularly reviewed. | N |
| Staff were clear about their roles and responsibilities. | Partial |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There were limited structures, processes and systems for the practice to review its own governance structures and systems. Ineffective governance arrangements were found on inspection. For example: - <ul style="list-style-type: none"> ○ The systems to assess, monitor and manage, safeguarding, medicines, significant events and information to deliver safe care and treatment were not always effective. ○ Patients' needs were not always assessed and care and treatment was not always delivered in line with current legislation. ○ The practice continued not to meet patient access needs. ○ We found overall, practice policies were not up to date and this was consistent with staff reports on inspection. The practice told us the registered manager who was also the lead GP had clinical oversight of all practice policies. However, we found significant gaps in the safeguarding policies that were outdated guidance from 2006. There were also gaps found within the anaphylaxis protocol document. • The practice had not maintained continued professional development and revalidation records for nurses. • We found GPs undertaking tasks that prevented them from reviewing the most urgent cases. | |

Managing risks, issues and performance

There were ineffective processes for managing risks, issues and performance.

| | Y/N/Partial |
|--|---------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | N |
| There were processes to manage performance. | Not inspected |
| There was a quality improvement programme in place. | Partial |
| There were effective arrangements for identifying, managing and mitigating risks. | N |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | N |

| | |
|---|---------------|
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Not inspected |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There were no comprehensive assurance systems in place to underpin essential standards to identify, manage and mitigate risk. This was in relation to referrals, medicines management, staff immunisations, infection control and ensuring there was also an effective process of oversight of mandatory and role specific staff training, such as for sepsis. We found a high staff turnover and also found there were not enough clinicians working in the practice as well as no clinicians onsite on Thursday afternoons, placing patients at risk in the event of an emergency. Following the inspection, the provider has stated they will ensure a GP is now on site. There were no assurance systems in the monitoring of unplanned admissions and at-risk patients, such as for children when they attended accident and emergency. | |

Engagement with patients, the public, staff and external partners

The practice did not always involve 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. | Not inspected |
| The practice had an active Patient Participation Group. | Not inspected |
| Staff views were reflected in the planning and delivery of services. | N |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Not inspected |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We did not see evidence where staff views were reflected in the planning and delivery of services. We saw examples where their views in relation to protecting staff against daily abuse from patients with behaviors of concern and the disconnect felt between staff and management were not acted on. | |

Continuous improvement and innovation

There was some 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. | N |
| Explanation of any answers and additional evidence: | |

- The practice told us they had a plan to develop their new nurses further so that greater responsibility and managing complexity would be built into their clinical portfolio with appropriate grade progression.
- The practice told us a new GP was due to start employment with the practice later in the year.
- There was limited evidence of learning being shared effectively and used to make improvements. This was in relation to significant events and patient safety alerts. Reception staff meetings were only via zoom and no longer face to face, which they felt was not an effective way to share learning and communicate with leaders in the practice.

Examples of continuous learning and improvement

In response to the initial findings of the inspection the provider submitted a list of learning and improvement. These included:

- Refocusing the Practice further on post pandemic improvement in quality.
- A more systematic and robust framework for medication monitoring particularly with high-risk drugs.
- Refocusing and innovating on Access.
- Galvanising the primary care network (PCN) to invest in high quality decision-making software and monitoring systems for all practices in the PCN and the employment of staff using The Additional Roles Reimbursement Scheme.
- Ensuring infection control matters, where accepted by the practice, and completed.
- Encouraging and supporting the practice to provide a more comprehensive and robust service.

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

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

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

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

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