

Care Quality Commission

Inspection Evidence Table

Gillmoss Medical Centre (1-10598315280)

Inspection date: 14, 15 and 16 December 2022

Date of data download: 9 December 2022

Overall rating: Requires improvement

At the last comprehensive inspection in March 2022 the practice was rated requires improvement overall and for safe, effective and responsive. Caring was rated good and well-led inadequate. We issued two requirement notices for Regulation 12 Safe care and treatment and Regulation 15 Premises and equipment. Conditions were imposed on the provider's registration in respect of a breach of Regulation 17 (Good governance).

At this inspection on 14,15 and 16 December 2022 we found that the provider had made improvements and met the requirement notices for Regulations 12 and 15 and met the conditions for a breach of Regulation 17 in part. In addition, other concerns were found.

We have rated the practice requires improvement overall and in the key questions safe, effective and well-led. Responsive and caring are rated as good.

We found a breach of Regulation 17 (Good governance).

Safe

Rating: Requires improvement

At our last inspection on 22 March 2022 the practice was rated as requires improvement for providing safe services. This was because:

- The provider could not evidence staff vaccination status.
- Fire risk assessment and a health and safety risk assessment of the premises had not been completed.
- We found risks related to the premises the provider had not identified. For example, bolt locks on clinical and toilet doors that could not be accessed externally. The entrance to the practice and some clinical rooms were not suitable for those in a wheelchair or those with a pushchair.
- The provider's system to manage significant events was ineffective as not all staff were trained in the process and records of investigations undertaken were not kept.

At this inspection on 14, 15 and 16 December 2022, we have continued to rate the practice requires improvement for providing safe services. This is because:

- Recruitment checks were not always carried out according to Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- There were gaps in systems to monitor and assess risks related to the health and safety of patients, staff and visitors.
- The provider did not keep cleaning records for the premises.
- The provider's system to manage significant events was ineffective as not all staff were trained in the process and records of investigations undertaken were not kept.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

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.	Y
Explanation of any answers and additional evidence: We reviewed 4 staff records and found that some did not contain the required pre-employment recruitment checks. We found that: <ul style="list-style-type: none"> • Two out of 4 files did not have satisfactory evidence of conduct in previous employment at the time of starting at the practice. • Two out of 4 files did not have a completed induction record present. • One out of 2 clinical files did not show the employees professional registration certificate. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 19 April 2022	Partial
There was a fire procedure.	Y
Date of fire risk assessment: 19 April 2022	Partial

Actions from fire risk assessment were identified and completed.	
<p>Explanation of any answers and additional evidence:</p> <p>Since our last inspection in March 2022 the provider had taken steps to complete some actions identified in the health and safety and fire risk assessments such as the removal of bolt pull locks on clinical rooms and toilet doors and updated general risk assessments. At this inspection in December 2022 we found that:</p> <ul style="list-style-type: none"> • Some substances that could be hazardous to health did not have an up to date associated safety data sheet in place. • The fire alarm had not been tested in the 4 weeks before the inspection. We were told that a break glass test point was broken and it had been escalated as a concern but had not been fixed at the time of the inspection. • There had only been one fire drill completed in the last 12 months. • The provider had a plan in place to move the cleaner's cupboard to the ground floor and works were due to commence in February 2023. 	

Infection prevention and control

The provider could not assure themselves that appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 15 November 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At the inspection on 22 March 2022 we were told that cleaning records were not available as the contractor had removed them from the premises. At this inspection in December 2022 we were told that cleaning schedules and records were not kept. The provider could not assure themselves that the premises were adequately cleaned in the absence of the records. • The provider had completed infection prevention and control audits and were working through actions at the time of the inspection. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y

There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence:	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> A review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance. 	

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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	1.24	0.91	0.82	Variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2021 to 30/09/2022) (NHSBSA)	2.6%	8.2%	8.5%	Significant Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r	5.66	5.45	5.28	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	231.1‰	224.9‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STARPU) (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small>	0.36	0.87	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>	7.7‰	11.3‰	6.7‰	No statistical variation

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

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

Medicines management	Y/N/Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence, including from clinical searches:	
As part of our inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. These searches were visible to the practice. We found that monitoring was appropriate overall, however:	
<ul style="list-style-type: none"> The clinical searches identified a total of 8 patients taking a medicine or group of medicines which may be used to treat inflammatory conditions. Of these we identified 5 patients who appeared to be overdue appropriate monitoring. We sampled 5 of these and found that there were problems with the care for 3 patients. The provider was not able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required. Of 16 patients prescribed potassium sparing diuretics (medicines to treat hypertension) we reviewed 5 records and found that 1 appeared to be overdue appropriate monitoring. There was evidence that the practice had tried to contact the patient for review but they had not responded. There were 545 people prescribed repeat medicines and we found that 329 people had received a medication review in the last 12 months. This equates to approximately 60% of patients who had received a medication review. We raised this with the provider during the inspection and we were told that they were working through the backlog. We found that oxygen and emergency medicines were checked monthly rather than weekly as recommended by the UK Resuscitation Council. 	

Track record on safety and lessons learned and improvements made

The practice had a system in place to learn and make improvements when things went wrong but this was not always effective.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
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:	6

Number of events that required action:	4
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff told us they knew how to report significant events. • We reviewed 2 significant events and found that there was a process in place to manage these, however there was no detail of investigations which meant that opportunities for learning may be missed. • Details about significant events across all of the provider's services were shared with staff at practice meetings but the minutes did not detail what the event was and the specific actions required to make improvements. • The person responsible for managing significant events had not received any training. We were told that the practice manager would be more involved in investigating these events, but changes had not been implemented at the time of the inspection. 	

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

Event	Specific action taken
Patient repeatedly presenting at accident and emergency units.	Additional support for patient at practice level implemented.
Patient not prescribed medication at request of secondary care.	Review and assessment carried out by GP.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • We saw examples of actions taken on recent alerts, for example, regarding sodium valproate. However, the provider was unable to demonstrate that all relevant safety alerts had been responded to. We saw that patients prescribed a medicine that could increase birth defects in pregnancy without anything in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered. • The provider kept a log of medicines safety alerts and disseminated information to the staff team. 	

Effective

Rating: Requires improvement

At the last inspection on 22 March 2022 we rated the practice as requires improvement for providing effective services. This was because:

- The staff induction process was not tailored to specific roles.
- Staff were not trained to the appropriate level for safeguarding children and not all staff were trained in cardiopulmonary resuscitation and health and safety matters.
- Appraisals had not been offered to all staff.

At this inspection on 14, 15 and 16 December 2022, we have continued to rate the practice requires improvement for providing effective services. This is because:

- The practice achievement in cervical cancer screening was below nationally set targets.
- People with long term conditions were not always reviewed in line with national guidance which required regular monitoring of their condition to prevent further harm.

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

Effective needs assessment, care and treatment

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

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

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- 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 took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

As part of this inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients with long term conditions were checked to ensure the required monitoring was taking place. We also reviewed the records of patients who may have an undiagnosed long term conditions. These searches were visible to the practice.

- We found that patients who required high dose steroid treatment for severe asthma were being reviewed by the practice. We identified that 1 of the 5 patients reviewed would benefit from a steroid emergency card as they were being prescribed a high dose of steroids.
- The clinical searches identified 4 out of 86 patients prescribed a medicine for an under active thyroid were not always reviewed in line with national guidance which required regular monitoring of their condition to prevent further harm. One of these patients had been contacted for a review but had not responded. The other records showed patients were overdue a review of their condition.
- We found that 20 patients had diabetic retinopathy. We sampled 5 of these records and found that 3 patients had not had a structured medication review. The records showed that the practice had not followed up on alerts in the clinical system to book these patients in for review.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	22	22	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	15	18	83.3%	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) (UKHSA COVER team)	15	18	83.3%	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) (UKHSA COVER team)	16	18	88.9%	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) (UKHSA COVER team)	32	32	100.0%	Met 95% WHO based target

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

Any additional evidence or comments

The practice was below the minimum 90% for 3 of 5 childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for two of five childhood immunisation uptake indicators. The smaller number of patients registered at this practice under the age of two affected the overall percentage.

Cancer Indicators	Practice	SICBL average	England average	England comparison
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The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	67.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	58.4%	54.1%	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)	46.0%	53.2%	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)	53.8%	51.5%	55.4%	No statistical variation

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

Any additional evidence or comments

The provider was aware of the lower achievement in cervical cancer screening. A locum practice nurse had been employed to offer patients cervical screening and the staff contacted patients to remind them to attend booked appointments.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

- The provider had an embedded programme of audit and we saw some examples of two cycle audits and improvements linked to prescribing practices.
- Other audits included an audit of patients prescribed omeprazole or esomeprazole as well as clopidogrel with the aim to check that all patients prescribed this combination of medicines had been reviewed. The provider had also carried out an audit of patients who had been issued more than 6 SABA inhalers in the last 12 months with the aim to check that all patients had been reviewed.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">At the last inspection in March 2022 we found that the systems in place for supporting staff needed to be improved. At this inspection in December 2022 we found that the provider had taken steps to improve the support systems for staff. For example, staff were provided with an employee handbook or locum pack and a full induction was available which was role specific. We also identified that annual appraisals were completed and supervision for clinical staff had improved with regular clinical supervision and clinical meetings being held.	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
Explanation of any answers and additional evidence, including from clinical searches: <ul style="list-style-type: none"> Our clinical review of notes where a DNACPR decision had been recorded identified, where possible, the patient's views had been sought and respected. We saw that information had been shared with relevant agencies and the provider had carried out an audit to check that all required information was present in the clinical records. 	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

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 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 (01/01/2022 to 30/04/2022)	68.4%	85.6%	84.7%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	74.7%	83.9%	83.5%	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 (01/01/2022 to 30/04/2022)	82.0%	93.4%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	55.0%	72.1%	72.4%	No statistical variation

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

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
Explanation of any answers and additional evidence:	

Source	Feedback
Feedback from patients during the inspection.	We were told: 'The lead GP is brilliant. They have been at the practice a long time and know me well. Nothing is ever too much for them.'

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 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 (01/01/2022 to 30/04/2022)	78.0%	90.4%	89.9%	No statistical variation

	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
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	There were 141 patients registered as carers at the practice which equates to approximately 6% of the practice population.
How the practice supported carers (including young carers).	There were no young carers registered at the practice. We were told that these would be identified through consultation.

How the practice supported recently bereaved patients.	Information about bereavement services was available at the practice. The provider's website also signposted patients to counselling services including bereavement counselling. We were told the provider sent cards to recently bereaved patients and this was followed up with a telephone call to check on their wellbeing soon afterwards.
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Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

Responsive

Rating: Good

At the inspection on 22 March 2022 we rated the practice requires improvement for providing responsive services. This was because:

- The provider did not keep records of investigations into complaints and a track of actions arising from complaints.
- Not all staff who dealt with and responded to complaints had received specific training.

At this inspection on 14,15 and 16 December 2022 we found that the provider had a process in place to manage complaints however there were no records of investigations kept.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • At the last inspection in March 2022 we found that the premises were not accessible for those in wheelchairs and prams and the provider had not undertaken an accessibility risk assessment of the premises. • At this inspection in December 2022 we found that the provider had widened the entrance door into the building to make it more accessible to people using wheelchairs and prams. However, the second door into the building made it difficult for people using wheelchairs and prams to enter the building easily. The provider had plans to make adjustments to a clinic room doorway to make it more accessible. 	

Practice Opening Times

Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8am to 6.30pm

Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

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.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

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

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 average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	44.4%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	45.5%	53.8%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	40.3%	54.7%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	72.8%	73.1%	71.9%	No statistical variation

Listening and learning from concerns and complaints

Complaints were listened and responded to but records lacked details of investigation.

Complaints	
Number of complaints received in the last year.	8
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At the last inspection in March 2022 we found that complaints were not always resolved in a timely manner. The provider did not keep records of investigations into complaints which meant that opportunities for learning was missed. At this inspection in December 2022 we found that the provider had a process in place to manage complaints and maintained a log to identify key themes and trends. The provider 	

responded to complaints in a timely manner and learning was disseminated to the team however, records of investigations were not kept.

- The person responsible for managing complaints had not received any training. We were told that the practice manager would be more involved in investigating these events, but changes had not been implemented at the time of the inspection.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient did not receive fit note after seeking advice from an administrative member of staff.	Additional training provided for administrative staff. Discussed at a practice meeting.
Delay in signing death certificate.	Reminder of death certificate process disseminated to all staff and discussed at practice meeting.

Well-led

Rating: Requires improvement

At the last inspection on 22 March 2022 we rated the practice inadequate for providing well-led services. This was because:

- Some members of the leadership team had been recently appointed and their roles and responsibilities had not been clearly set out and were still being developed.
- Practice staff were not always aware of the roles and responsibilities of members of the leadership team and the lines of accountability within the organisation.
- The provider's centralised governance function did not have clear systems and processes in place to support staff at practice level.
- The provider did not have a documented overall strategy underpinned by detailed, realistic objectives and plans for high-quality and sustainable delivery.
- The systems for identifying, managing and mitigating some risks were ineffective.
- There was no leadership development programme in place.
- The vision, values and strategy were not developed in collaboration with staff, patients and partners.

At this inspection on 14, 15 and 16 December 2022 we rated the practice requires improvement for providing well-led services. We found that:

- The provider had employed a practice manager to oversee the day to day management of the practice. Practice staff were aware of the roles and responsibilities of the leadership team at practice and organisation level.
- Some responsibilities had been delegated to the practice manager and there were plans for them to take on more leadership responsibilities following the inspection.
- The provider had implemented an overall strategy and 5 year plan for the practice but this lacked detail.
- The provider had implemented a leadership development programme.

However:

- Although the practice had made changes to the management of the practice, these had not had time to demonstrate effectiveness.
- The systems for identifying, managing and mitigating some risks were not always effective.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The provider held contracts for a number of GP practices and they were, in effect, providing services at scale. At our last inspection in March 2022 we found that some of the operational	

and governance structures to support the practice were centralised and in the development stages. At this inspection in December 2022 the provider had employed a practice manager who had assumed some responsibility for the day to day management of the practice. The provider had a plan in place to transition from a central governance team to management oversight at practice level.

- We experienced some challenges in getting access to key pieces of information we required to carry out the inspection visit. For example, we requested information be sent to us before the inspection and we did not receive this.

Vision and strategy

The practice had a clear vision but it was not supported by a detailed 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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The provider had developed an overall strategy and 5 year plan for the practice but this lacked detail. For example, the plan showed information about improvements to the premises but did not detail information about the plans for the delivery of high quality and sustainable care. • There was no evidence of staff being involved in strategic planning but discussions we had with staff during the inspection indicated that they were able to share ideas about how to deliver services and these were acted on. 	

Culture

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

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

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

Source	Feedback
Staff feedback during the inspection	<p>We were told:</p> <ul style="list-style-type: none"> • This is a brilliant place to work, everyone supports each other. The leaders are always visible and I can talk to them about anything. • The practice manager and provider are very approachable and supportive. • The lead GP can be contacted at any time for support. Nothing is ever too much for them.

Governance arrangements

The overall governance arrangements were under review.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
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"> • At the last inspection in March 2022 we found that the provider did not have clear systems and structures in place to demonstrate effective and sustainable governance of the service. The provider had centralised systems for governing the service which were not embedded and we were concerned about the sustainability of the systems at practice level. • At this inspection in December 2022 we found that the practice manager had taken on more leadership responsibilities such as recruitment and staff files. We were told that the practice manager was due to take on responsibility for practice meetings and the central management of complaints in January 2023. 	

Managing risks, issues and performance

There were processes for managing risks, issues and performance but they were not always effective.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p>	

- At the last inspection in March 2022 there were gaps in systems to assess, monitor and manage risks to patient safety. For example, there were no risk assessments in place for health and safety or fire safety and we saw cleaning materials stored in an unlocked cupboard.
- At this inspection in December 2022 we found the provider had made some improvements to the processes for assessing, monitoring and managing risks to patient safety. For example, the practice manager had taken on responsibility for updating risk assessments relating to the premises however, we found shortfalls with the records to support these processes. For example, the health and safety, complaints and significant events policy were all overdue a review. We were told that these were working documents and were continually reviewed but the review date had not been changed on the document. The provider told us all policies would be reviewed following the inspection.

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.	Partial
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The provider did not use data from patient surveys to monitor and improve performance. 	

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
Explanation of any answers and additional evidence:	

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.	Partial
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">We were told that there was no Patient Participation Group (PPG) at the practice and no recent patient survey had been carried out. We saw evidence of the provider seeking feedback from patients using feedback forms that were placed in the waiting area and were told that these were reviewed once received and changes made to the service where possible.	

Continuous improvement and innovation

There were 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:	

Examples of continuous learning and improvement

- All staff had access to a variety of training opportunities to support them in their roles and in their continuing professional development.

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

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

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

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

Glossary of terms used in the data.

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