

Care Quality Commission

Inspection Evidence Table

Park Lane Surgery

(1-552122653)

Inspection Date: 24 October 2023

Date of data download: 05/10/2023

Overall rating: Requires Improvement

Safe

Rating: Inadequate

We rated the practice as Inadequate due to:

- Monitoring of medicines was not always completed in line with national guidance.
- We saw evidence safety alerts were not always actioned in a safe manner.
- Not all staff were trained appropriately for their role.

Safety systems and processes

The practice did not always have 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.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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.	Yes

<ul style="list-style-type: none"> • The practice had systems in place to safeguard children and vulnerable adults from abuse. This included policies and procedures which were accessible to staff on a shared drive. • The practice had a safeguarding lead in place to manage and support the safeguarding of adults and children. • Not all staff had completed the required safeguarding training for their role. The practice showed us a training matrix where we saw a GP who was out of date for safeguarding training. The provider told us they had requested the GP complete this training. Following our inspection, the practice showed us all staff had completed safeguarding training. • All staff knew how to identify and raise safeguarding concerns. The practice shared examples of suspected safeguarding and how these were reported. • The practice worked with other agencies to safeguard people from risk of abuse. For example, the practice held meetings with local midwives, health visitors and discussed with the local authority where required. • Clinicians followed up children who did not attend appointments or had required secondary care attendances.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<ul style="list-style-type: none"> • We reviewed a random sample of staff recruitment files and found not all staff had the required information held within their recruitment files. For example, we random sampled 5 staff files and found not all right-to-work documentation and proof of full employment history was included in each recruitment file. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment: 7 February 2023	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 18 July 2022	Yes
Actions from fire risk assessment were identified and completed.	Partial
<ul style="list-style-type: none"> • Staff had access to a health and safety policy and knew how to report accidents and incidents. • The practice carried out a health and safety audit in February 2023. Areas for action had been documented and we saw these had been addressed, however, the practice had not updated the risk assessment to sign actions as completed. • The clinical surgical room required upgrading to meet health and safety standards, for example, the window glass required replacing and a medical couch required replacing as it was torn. Post inspection, we were sent a risk assessment for the surgical clinical room dated December 2022. We have not seen an updated risk assessment following the completion of these remedial works on 30 October 2023. • Fire extinguisher servicing had been completed in October 2023 by an external contractor. • All staff had completed training concerning health and safety. 	

- We saw fire training had been completed by all staff and there were 4 fire wardens at the practice who had completed extra training for this role.
- Emergency lighting checks were completed in October 2023.
- Equipment calibration testing had been completed and undertaken by an external contractor.
- The fire risk assessment had indicated the smoke detectors be renewed due to age. The provider told us this had been arranged to be completed in January 2024.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were mostly met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 21 August 2023	Yes
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.	Yes
<ul style="list-style-type: none"> • A staff training matrix showed all but 1 staff had completed infection and prevention control training. Furthermore, all but 2 staff had completed COVID-19 refresher training. The provider was aware of this and had agreed on training hours for these staff to complete. Following our inspection, the practice showed us all staff had completed training. • There was an infection prevention and control lead for the practice who undertook audits and competencies on the staff. The last infection control audit was completed in August 2023. • An external inspection for infection prevention and control was completed in November 2022. Actions required following this audit were ongoing. Following our inspection, the practice sent us evidence to show this was completed. 	

Risks to patients

There were some gaps in 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.	Partial
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Partial

- A rota system was in place to manage staffing. At the time of our inspection, there were high levels of sickness in the non-clinical staff team. Other colleagues would cover the rota shortages and could work excess contract hours. The provider was aware and was in the process of recruiting an apprentice and other non-clinical staff to support periods of absence.
- If the practice was to use a locum, a locum pack was used and completed.
- Staff knew how to notify and seek help for patient deterioration. A staff training matrix showed not all staff had completed training the practice deemed mandatory. Furthermore, all but 2 staff had completed COVID-19 refresher training. The provider was aware of this and had agreed on training hours for these staff to complete. Following our inspection, the practice showed us all staff were completing this training.
- We identified 12 staff had not completed anaphylaxis (a severe life-threatening allergic reaction) training. Following our onsite inspection, the practice showed us 4 staff had completed this training and 2 staff were being given allocated protected time to complete this training or offered paid overtime to complete.
- A staff training matrix showed not all staff had completed training the practice deemed mandatory.
- Following our inspection, the practice showed us all staff were booked into complete this training.

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.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<ul style="list-style-type: none"> • Informal discussions would occur with specific patient queries by clinical staff to their manager or GP were welcomed, however, the focus was on the clinical presentation and not the content of records. We asked the provider to implement a structured approach to ensure care records were in line with current guidance and legislation. • Our clinical searches found incorrect coding on patient records identified in our clinical searches, showed the practice workflow processes required strengthening. For example, we found clinical correspondence letters coming into the practice had been incorrectly coded on over 500 patients. The provider had responded to the clinical search findings and implemented a protocol by the time we went on our onsite inspection. • Summarising patient records had no outstanding tasks due to the provider digitalising all paper records held at the practice and the paper patient records had been moved offsite into secure storage. • Urgent referrals were sent on time and there was a follow-up process for referrals made. • We found 45 overdue test results, the oldest dated back to 11 October 2023. Additionally, not all overdue test results had been reviewed by a clinician. We informed the practice who addressed all outstanding test results. 	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	1.28	0.97	0.91	Tending towards 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). (01/07/2022 to 30/06/2023) (NHSBSA)	11.7%	8.2%	7.8%	Tending towards variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	7.22	5.37	5.24	Significant variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	80.6‰	96.7‰	129.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.85	0.47	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	2.0‰	5.5‰	6.8‰	Significant variation (positive)

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

Any additional evidence or comments

- The practice was aware they had a higher use of antibiotics than the national average. Due to an older patient demographic, the use of antibiotics use has always shown prevalence. The practice told us they were meeting with the local integrated care board pharmacy team in November 2023 to discuss this and gain insight into their prescribing data about the local GP services in the local area. The aim was to explore data analysis and develop auditing tools to monitor themes and trends and use this to educate the clinicians at the practice.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes

Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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.	Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<ul style="list-style-type: none"> Non-medical prescribers were able to discuss patients with a clinician if they required support on a consultation, however, there was no formal documented supervision for oversight of prescribing competency. The provider was asked to implement this to assure themselves of non-medical prescribers. We identified 69 out of 128 patients were prescribed gabapentoid (a medicine used for neuropathic pain or antiepileptic) and further reviewed 5 patients. We found all 5 patients had not received appropriate monitoring or had a medicine review completed. We asked the provider to review these patients and they provided a detailed action plan demonstrating actions taken. In the past 3 months, we saw 624 patients had been given a medicines review by a clinician. We further reviewed 5 patient records and all 5 patients had no concerns found with the review. Following our inspection, the provider implemented a structured approach to medicine monitoring and employed a full-time monitoring and safe prescribing clerk to assist clinicians. Regular clinical searches were planned weekly to ensure all patients who required testing for any medication had all completed in one appointment to streamline the process. The emergency medicines at the practice were individually boxed mostly in a locked storage cupboard and not easily accessible if an emergency occurred. There was a grab bag also available that required 	

reviewing due to loose medicine vials found in a zip holder. The vials were held by an elastic loop and the labels of medicines could not be seen. We discussed concerns of potential risks to emergency medicine storage if a clinical emergency occurred with the provider. They told us they agreed a more central location was safer for in the event of a clinical emergency and would immediately review how these medicines were. Following our inspection, the provider sent evidence of this emergency trolley in the central location.

Track record on safety and lessons learned and improvements made

The practice did not always have 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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	11
Number of events that required action:	11
<ul style="list-style-type: none"> There was a system of recording and acting on significant events. Staff understood their duty to raise concerns, report any incidents and near misses. Significant events were a standing agenda at the partners and practice meetings. The practice showed us a risk register that included details of significant events not documented on the significant events register. The provider submitted evidence post-inspection to demonstrate a significant event log had been implemented. A staff training matrix showed all but 1 staff had completed training the practice deemed mandatory. The provider was aware of this and had agreed on training hours for these staff to complete. Following our inspection, the practice showed us all staff had completed training. 	

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

Event	Specific action taken
Vaccines Fridge failure.	Staff responded by following the protocol, this was escalated to the external contractor, and advice on vaccines was given to move them, and if any stock was potentially temperature damaged, disposed of. The provider bought another specimen fridge as a backup in case of future fridge failures.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial

Staff understood how to deal with alerts.	Partial
<ul style="list-style-type: none"> • The provider was unable to demonstrate that all relevant safety alerts had been responded to. We saw that patients remained on combinations of medicines (a cholesterol medicine Simvastatin) increasing in concentration if prescribed with some heart medicines (Amlodipine), the cholesterol medicine should be reduced in dose. • We identified 19 patients who were still prescribed a higher cholesterol dose of medicine (statin) when used in conjunction with certain medications (amlodipine/diltiazem/verapamil), and there was no indication within the patient's records to demonstrate they had been identified, reviewed, or had a discussion of medicine options. We asked the provider to review these patients and this was confirmed as completed by the practice. • Following our inspection, the provider implemented a structured approach to medicine monitoring and employed a full-time monitoring and safe prescribing clerk to assist clinicians 	

Effective

Rating: Requires Improvement

Effective needs assessment, care and treatment

Patients' needs 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.	Yes
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.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
<ul style="list-style-type: none"> The practice had systems to keep clinicians up to date with current evidence based practice, however, we found that some areas of medicines management required strengthening. For example, we found over 500 patients had been incorrectly coded. for example, 265 patients who had a potential missed diagnosis of chronic kidney disease (CKD) stages 3, 4, or 5. We further reviewed 5 patient records and found 3 of these patients had a missed diagnosis of CKD 3, whilst 1 patient was overdue monitoring. The provider told us they recognised there had been some clinical coding errors and showed us an action plan for how they would review these patients. On the day of our on-site inspection, these patients had been correctly coded or invited for further blood monitoring to confirm if a diagnosis was required. We found 48 out of 1268 patients prescribed an ace inhibitor heart medicine had not received the appropriate monitoring. We further sampled 5 patient records and found 2 of these patients had not received blood pressure monitoring within the last 18 months. We discussed this with the provider who told us these patients had been contacted and provided us with a detailed action plan to ensure all 48 patients had the appropriate monitoring. 	

Effective care for the practice population

Findings

- 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 an appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. There were 576 patients eligible for a health check and 199 (34%) had been completed in the last 3 months
- There were 42 patients diagnosed with a learning disability who were offered an annual health check. The practice had completed 3 checks at the time of our inspection. The provider told us they had not completed these learning disability reviews and had a plan to commence them. The provider invited patients in this group to have health checks completed during January to March annually.
- 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

- Most patients with long-term conditions were offered an effective annual review to check their health and medicine needs were met.
- Our clinical searches reviewed patients who were diagnosed with asthma and who had been prescribed 2 or more courses of rescue steroids. There were 65 out of 1130 patients identified. We further reviewed 5 patient records and found 3 patients had not received a follow-up within 1 week of the prescription of steroids. The practice told us they were reviewing all these patients and showed us a protocol they had implemented to ensure all asthma patients were monitored effectively.
- We found that 7 out of 27 patients diagnosed with chronic kidney disease stages 4 or 5 had potentially not received the appropriate monitoring. Additionally, 2 of these patients had not had their diagnosis updated and we asked the provider to review these patients. During our onsite visit, the practice showed us they had reviewed all these patients.
- We found 365 patients diagnosed with hypothyroidism and 15 of them had not had the appropriate monitoring in 18 months. We reviewed a random sample of 5 patient records and identified 3 of these patients were overdue blood monitoring.
- Our clinical searches found 571 patients with diabetic retinopathy. Of these, 40 patients had an HBA1C blood test above 74mmol and overdue medicine reviews and blood pressure readings. We asked the practice to review these patients. We further random-sampled 5 patients and saw the reviews had been satisfactorily completed.
- Following our inspection, we received evidence to demonstrate the practice had contacted all patients identified in our clinical searches.
- 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.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	98	110	89.1%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	78	83	94.0%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	79	83	95.2%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	77	83	92.8%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	97	100	97.0%	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 would follow up with children who did not attend immunisation appointments, encourage flexibility for appointments and encourage the use of the local GP federation to support immunisation appointments.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	75.5%	N/A	62.3%	N/A

Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	79.5%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (3/31/2023 to 3/31/2023) (UKHSA)	81.3%	N/A	80.0%	Met 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	36.5%	54.3%	54.9%	Tending towards variation (negative)

Any additional evidence or comments

- The practice employed a cancer care coordinator who would contact patients if they missed appointments, had diagnosis queries, and arrange care reviews as they were aware they had a lower detection rate than lower and national averages.

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.	Partial
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
<ul style="list-style-type: none"> The provider was aware they had not completed as many quality audits. They had completed an opioid audit and identified 12 patients who had been reviewed. The practice told us they had arranged a meeting with the local integrated care board to undertake an antibiotic prescribing audit and told us they were planning to make an improved audit schedule. 	

Effective staffing

The practice was not always 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.	Partial
The practice had a programme of learning and development.	Yes

Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
<ul style="list-style-type: none"> The practice was aware they had gaps in staff training and had encouraged staff to complete their training. Incentives for overtime or paid training were utilised to improve uptake. The practice was aware that protected time for mandatory training was not always available due to operational requirements. The provider told us they would be restructuring the training to ensure all staff completed on time. Following our inspection, the practice confirmed infection control training had been completed. We found not all staff had received their annual appraisals and the practice told us they were aware and had appointments booked. We were aware of significant events where learning for staff could be demonstrated, however, upon reviewing staff files, we were unable to find records of staff discussions or disciplinary actions and it was unclear if staff were held accountable should things go wrong. 	

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
<ul style="list-style-type: none"> Systems were in place to share information electronically with other services. We saw evidence of regular staff meetings to ensure staff were kept up to date with guidance and best practices. The practice was part of the primary care network and had access to services within it. The practice attended MDT meetings within the locality to coordinate care. 	

Helping patients to live healthier lives

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

	Y/N/Partial
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The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
<ul style="list-style-type: none"> The practice shared relevant information with the out of hours service to support continuity of care. The practice attended MDT meetings across the locality which were attended by other practices and professionals where appropriate for example, district nurses, social services, care coordinators and the palliative care team. 	

Any additional evidence or comments	
<ul style="list-style-type: none"> The practice had employed a social prescriber who would support patients by signposting to other support agencies, such as smoking cessation or housing advice. 	

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

Caring

Rating: Good

We rated the practice as requires improvement due to:

- Patient satisfaction had declined in some areas.
- Patient survey data collation was lacking in some areas to drive improvements.

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
<ul style="list-style-type: none">• Staff we spoke with demonstrated the values of the practice and dealt with patients with kindness, respect, and compassion.• Interactions we observed between staff and patients, showed that staff listened to patients and treated them with kindness.	

Patient feedback	
Source	Feedback
NHS Choices	There were 6 patient reviews of caring staff and patients described the staff as 'listening, compassionate and superb'.
Patient Feedback	We spoke with 3 patients who described the nursing staff as 'helpful' and made to feel listened' to. Patients were made to feel part of any decision-making process in their care.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	85.8%	84.6%	85.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare	85.5%	82.6%	83.8%	No statistical variation

professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	89.6%	94.4%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	67.7%	70.1%	71.3%	No statistical variation

Any additional evidence or comments

- There were mixed outcomes of patient survey data in relation to patient experience. We were not shown any evidence of the practice undertaking their own feedback exercises into patient care.

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

Any additional evidence

- We did not see any evidence the practice completed any patient survey about patient experience or friends and family test exercises. The primary care network collated data from patients, however, the amount of patient feedback analysis was limited and we saw downward trends since 2020 within the national GP patient survey.

Involvement in decisions about care and treatment

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

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

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they	85.5%	90.7%	90.3%	No statistical variation

wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)				
Any additional evidence or comments				
<ul style="list-style-type: none"> Patient feedback we received showed patients felt involved with their care, however, we did not see any evidence that the practice had addressed their lower than national average survey data. 				

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

Carers	Narrative
Percentage and number of carers identified.	There were 424 carers (24%) registered at the practice. Carers were encouraged to register at the practice, and this began on patient registration forms. Carers had access to support information in the practice and online.
How the practice supported carers (including young carers).	There were 4 young carers registered at the practice. There would be annual carer checks completed, prioritisation for health checks and immunisations and the practice would also provide check ins for their young carers to welfare check.
How the practice supported recently bereaved patients.	The practice would call the families and they would undertake a welfare check, mental health check and provide signposting to support services of the families. The practice had an internal system so all staff were aware that if any family members came to the practice, they could offer support to the families.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Requires Improvement

We recognise the pressure that practices are currently working under, and the efforts staff are making to maintain levels of access for their patients. At the same time, our strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. Although we saw the practice was attempting to improve access, this was not yet reflected in the GP patient survey data or other sources of patient feedback. Therefore, the rating is Requires Improvement, as ratings depend on evidence of impact and must reflect the lived experience that people were reporting at the time of inspection.

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.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<ul style="list-style-type: none"> The provider education for patients in providing appointments was an area for improvement. Some patients would respond negatively to alternative clinician appointments offered, for example, a nurse practitioner rather than a GP. The practice told us they had recognised patients did not always know how each of the clinical roles meant a GP was not always the best clinician. During our inspection, we did not see any action plan for how this barrier would be addressed. We saw patient awareness of the role of the primary care network booking system was lacking. Patients did not understand the benefits of an extended care network and we saw some negative patient feedback that the practice was "making them go out of their way for an appointment elsewhere". The provider recognised communication for access could be further developed. Recruitment was ongoing at the time of our inspection following the retirement of a GP, and there had been a period of sickness among non-clinical staff which had placed pressure on the practice with regard to practice access. Due to lack of patient education for access to appointments, patients felt they had their choices taken away for booking appointments. The provider told us they would create an action plan to address these barriers to understand the needs of patients more effectively. 	

Practice Opening Times

Day	Time
Opening times:	
Monday	8 am – 1 pm

	2 pm – 6.30 pm
Tuesday	8 am – 1 pm 2 pm – 6.30 pm
Wednesday	8 am – 1 pm 2 pm – 6.30 pm
Thursday	8 am – 1 pm 2 pm – 6.30 pm
Friday	8 am – 1 pm 2 pm – 6.30 pm
Appointments available:	
Monday	8 am – 1 pm 2 pm – 6.30 pm
Tuesday	8 am – 1 pm 2 pm – 6.30 pm
Wednesday	8 am – 1 pm 2 pm – 6.30 pm
Thursday	8 am – 1 pm 2 pm – 6.30 pm
Friday	8 am – 1 pm 2 pm – 6.30 pm
Extended Access was available for patients outside of practice opening hours through NHS 111.	

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 was open until 6.30 pm Monday to Friday. Appointments were available out of hours via NHS 111.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice offered personalised and co-ordinated care by referring patients to other services within their primary care network. For example, physiotherapists and mental health clinicians.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial

The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
<ul style="list-style-type: none"> Patients could book appointments via telephone or face to face. Patients also had the option to contact the practice using an online system (a digital triage platform that allowed patients to make medical or administrative requests). The practice had not completed any analysis of how many patients telephoned the practice weekly to identify improvements. The provider had recognised patients found long telephone holds to make appointments frustrating and had implemented a call-back feature. This allowed the patient to be called back when they were second in the queue. Feedback from patients on this feature was positive. The provider had systems in place to manage the availability of routine and urgent appointments. Some face to face appointments were reserved to enable a clinician to book an appointment for a patient on the same day if they felt it was appropriate. We saw information on the practice's website to help support patients to understand how to access appointments and other services. If a patient telephoned the practice out of hours, they would be diverted accordingly. The provider told us there was a new electronic consult being implemented in December 2023 for patients to have access to request appointments more easily. 	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	26.4%	N/A	49.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	52.5%	50.7%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	36.9%	48.2%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or	68.3%	70.2%	72.0%	No statistical variation

appointments) they were offered (01/01/2023 to 30/04/2023)				
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Any additional evidence or comments

- The primary care network collated data from patients, however, the amount of patient feedback analysis was limited and we saw downward trends since 2020 within the national GP patient survey. The provider was part of a local primary care network and had introduced 6 extra appointments at local practices on a Saturday morning for patients to access.
- Other appointments included 4 nurse appointments on a Saturday for long term condition health checks, dressings and patient screening.

Source	Feedback
NHS.uk website (formerly NHS Choices)	We saw 11 negative responses with regards to access, especially surrounding being able to get through to the practice via the telephone. Not all of this feedback had been responded to by the provider.
Patient Feedback	We spoke to 3 patients who told us they found it difficult to make appointments. The lines could place them on hold for long periods of time and they found if there were no appointments available, the onward options for NHS 111 were not always welcomed. There was negative feedback to flexibility of appointments also noted.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	27
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.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes

Example(s) of learning from complaints.

Complaint	Specific action taken
Telephone system options and staff attitude when got through to speak to the practice.	The provider held a partners meeting and recognised the automated telephone message was unclear on what constitutes a medical emergency, rather than an emergency appointment required. The practice contacted their telephone provider to change the automated message. All staff who answered telephones were

	given refresher training in dealing with patients who required help with an appointment.
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Well-led

Rating: Requires Improvement-

Leadership capacity and capability
Leaders could not always 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.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
<ul style="list-style-type: none"> Clinical leadership and clinical supervision were not always provided in a structured documented approach, although staff told us leaders were approachable at any time. Staff told us that the leadership team took the time to listen to staff and had an open-door policy. We saw important information was shared with staff via meetings and emails. For example, learning from significant events and complaints, discussion about the availability of appointments and administrative duties. Following our inspection, the practice was recruiting additional staff, including a GP, non-clinical staff and an administrative apprentice. 	

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

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

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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<ul style="list-style-type: none">We spoke with 9 members of staff who told us there was an open culture within the practice, the leadership team were approachable, they felt comfortable raising any issues and felt confident and supported in doing so.	

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

Source	Feedback
Staff Interviews	Staff described the practice as 'a comfortable atmosphere' and 'great sense of teamwork'. Other staff described the practice as 'friendly' and 'supportive'.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
<ul style="list-style-type: none">We found that improvements to some systems were still required. For example, systems in relation to the monitoring of some medicines, long-term conditions and the management of safety alerts.	

Managing risks, issues and performance

Improvements in processes for managing risks, issues and performance were still required.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<ul style="list-style-type: none">Systems and processes required strengthening for managing risks in relation to high-risk medicines, medicine reviews, medicine usage (such as Gabapentoids), safety alerts and long-term condition monitoring. The provider completed 69 Gabapentoid medicine reviews following our inspection.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<ul style="list-style-type: none">Although the practice completed some patient and staff surveys, there was little evidence to demonstrate action planning for results collated and we did not see any improvement plans.At the time of our inspection, the provider had no staff who were under performance management.	

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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes

Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes
<ul style="list-style-type: none"> All paper versions of patient notes had been digitalised prior to our inspection and had been moved off site to a secure location. 	

Engagement with patients, the public, staff and external partners

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

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

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> There were 40 members within the patient participation group (PPG), and they told us that they would like to have more involvement with the practice for patient feedback and projects. For example, working together with the practice to address barriers or patient frustrations, such as access to appointments.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Yes

- The practice encouraged learning and development of staff and shared analysis of significant events during staff meetings, however, there was minimal evidence we saw in relation to innovation and improvement through audits. The provider told us they were aware of some gaps and had improved an audit schedule that included local external stakeholders in order to improve continued 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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

Glossary of terms used in the data.

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