

Care Quality Commission

Inspection Evidence Table

Chapel St Surgery (1-9298534575)

Inspection date: 28 September 2022 to 10 October 2022

Date of data download: 21 September 2022

Overall rating: Requires improvement

- The practice did not always have clear systems, practices and processes that were consistently followed.
- There were some concerns around the management of medicines and review of patients with long-term conditions.
- The practice did not always have clear and effective processes for managing risks, issues and performance.

Safe

Rating: Requires improvement

The practice is rated **requires improvement** for providing **safe** services because:

- Not all systems for the recruitment of staff were satisfactory.
- Systems for managing risk were not complete and lacked clear responses to assessed risk.
- The practice could not demonstrate that medicine management was appropriate for patients on high risk medicines. Patient did not always receive the required up to date healthcare monitoring.

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.	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

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
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
<p>Explanation of any answers and additional evidence:</p> <p>Not all staff had appropriate disclosure and barring scheme (DBS) checks on record. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We looked at 6 staff files and reviewed these with practice staff, as documentation was contained within multiple recording systems. Two staff members did not have a DBS check, this included a clinical staff member. One further member of staff had a standard check and we noted this person was in a position that would require an enhanced check. There were no risk assessments carried out for staff who did not have a DBS check in place.</p> <p>The children's safeguarding policy was effective from September 2019 and had a review date of September 2022. Although the policy was comprehensive, it referred to out of date guidance from 2014. The policy stated that each of the provider's GP practices must have a nominated practice lead for safeguarding children and prevent (PREVENT is about recognising when vulnerable individuals are at risk of being exploited for extremist or terrorist-related activities). However, the policies did not identify who this was in the practice. The contact sheets within the practice for local safeguarding teams were not up to date and did not include all of the relevant contact details.</p>	

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.	N
<p>Explanation of any answers and additional evidence:</p> <p>We looked at 6 staff files and reviewed recruitment documentation. They did not provide assurance that recruitment checks were carried out in accordance with regulation. For example, of the 6 staff files we looked at, 4 did not have satisfactory evidence of conduct of the staff member in previous employment. This is usually in the form of a written reference. Two records had only one reference, this was not in line with the practice policy.</p> <p>The practice did not have a complete record of staff vaccination in line with their own policy or current UKHSA guidance. We found that, 5 out of 14 clinical staff did not have complete records of immunisation and 8 out of 22 administration staff and other staff did not have complete records of immunisation. Three staff had no record. The practice policy stated that risk assessments will be undertaken if staff don't have immunisations in line with guidance, however, there was no record in the spreadsheet of these taking place when required.</p>	

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: 20/01/2022	
There was a fire procedure.	Y
Date of fire risk assessment: 20/01/2022	Partial
Actions from fire risk assessment were identified and completed.	
Explanation of any answers and additional evidence:	
Health and safety, legionella and fire risk assessments were in place, however the response to the actions set out in these documents was not completed. Following the inspection site visit, the practice undertook a review of these assessments and provided an update on these areas. However, there remained gaps in this plan.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Partial
Date of last infection prevention and control audit: 15/09/2022	
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
We saw evidence that an infection control audit had taken place. However, we looked at the audit and we were not assured that all potential infection control risks had been assessed and identified. For example, we observed a number of work surfaces that had damage to edging and this was not recorded on the audit. This would prevent the proper cleaning of these surfaces.	

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:	

We noted concerns from the staff team on significant shortfalls in nursing staff over the previous year. The provider told us that they had reviewed the skill mix and had introduced systems to improve the staff levels. Including the assistance of remote consultations by SPC connect (a remote service provided by the provider Sussex Primary care Ltd). This was under review and will be reviewed at a future inspection.

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. ¹	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	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

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.90	0.83	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	7.6%	9.1%	8.5%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2022 to 30/06/2022) (NHSBSA)	5.22	5.95	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	226.9‰	150.2‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	1.22	0.88	0.59	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	18.5‰	10.2‰	6.8‰	Significant Variation (negative)

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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	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. ²	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

Medicines management	Y/N/Partial
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>We conducted searches of patient records. These searches were indicative of the number of patients potentially at risk due to a lack of monitoring or diagnosis. Risk was not conclusive and further investigation of the patient record was needed to assess the potential risks.</p> <p>A CQC GP Specialist Advisor sampled a select number of patient records, where any risks were potentially identified, to assess the risks for these individual patients. The searches we carried out and subsequent examination of patient records during our inspection found that, in most instances, all the required up to date health monitoring had been completed. However, some areas required further action;</p> <ul style="list-style-type: none"> • Our searches indicated that 4 patients prescribed an immunosuppressant were potentially overdue blood tests. On further examination 1 was overdue. • Our searches indicated 5 patients prescribed a potassium sparing diuretic were identified as not having the required monitoring (diuretics are used to increase the amount of fluid passed from the body). We found 2 patients were overdue blood tests by 5 months and 18 months. 	

Track record on safety and lessons learned and improvements made

The practice could not demonstrate they learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
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.	Partial
There was evidence of learning and dissemination of information.	Partial

Number of events recorded in last 12 months:	9
Number of events that required action:	9
Explanation of any answers and additional evidence:	
<p>We reviewed the practice significant event log and noted 9 events logged between October 2021 and October 2022. It was not clear from these records how information and learning was shared widely in the practice. For example, the column marked “how is learning disseminated” only contained information about actions in 7 out of 9 records. There was little evidence of wider dissemination.</p> <p>Two significant events had not been marked as complete, 1 was raised 17/10/2021 and 1 on 23/03/2022. Both stated that further discussion was needed, and the completion date was to be agreed. No further information was available. We reviewed 2 significant event forms and found in one it was not possible to fully track the significant events through the significant event form and log. One of the significant event forms had no log number completed, but the title differed to the content of the form, which was related to back pain and diazepam prescribing. In this significant event form, there was no record that the event had been discussed with the prescribing GP (who was not present at the meeting where it was discussed).</p> <p>It was unclear if all incidents and events had been recorded. For example, during the inspection we were made aware of another significant event when staff attended to a collapsed patient in a nearby pharmacy. There was a positive response by staff that had not been reflected in the practices event log. We also noted a complaint had not been responded to for a significant amount of time. This had been found by staff but not been entered into the log as a significant event.</p>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
<p>We saw examples of actions taken to respond to medicine alerts and other safety alerts.</p> <p>However, the examination of patient records from the clinical searches identified deficiencies in the system of responding to safety alerts. The practice was unable to demonstrate that all relevant safety alerts had been responded to fully. We saw that patients remained on medicines or combinations of medicines that increased their risk. We did not see evidence in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered.</p> <ul style="list-style-type: none"> We looked at the records of patients of childbearing age prescribed an anticonvulsant medicine (for the treatment of epilepsy). We were unable to locate evidence within the records that 2 patients had been informed of the risks associated with this medicine, as alerted by the Medicines and Healthcare products Regulatory Agency (MHRA) in April 2022. We viewed the records for 4 patients who were above 65 years of age, prescribed a certain medicine to treat depression. We were unable to locate evidence within the records that 3 patients had been informed of the risks associated with this medicine, as alerted by the Medicines and Healthcare products Regulatory Agency (MHRA) in December 2014. 	

Effective

Rating: Requires improvement

At this inspection, we found that the practice requires improvement for providing effective services because:

- Improvements were needed to the management of long-term conditions
- Inductions were incomplete
- A programme of clinical supervision was not in place.

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

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: With the consent of the practice, a CQC GP Specialist Advisor accessed the practice's systems to undertake remote searches. These searches indicated the number of patients potentially at risk due to a lack of monitoring. A further investigation of patient records was undertaken to assess the potential risks. The CQC GP Specialist Advisor sampled a select number of patient records, where any risks were potentially identified, to assess the risks for these individual patients.	

In most cases patients with long term conditions received appropriate follow up and review. However, some searches identified where improvement was needed:

Our searches indicated 21 patients with a potential missed diagnosis of diabetes. We looked at 5 patient records and found concerns with the monitoring intervals and coding of patients. For example, 3 of the 5 patient records had not been coded correctly and another patient was not retested at the correct intervals in line with national guidance.

We searched for patients with a diagnosis of chronic kidney disease (CKD) who had not received appropriate monitoring in the last 9 months. We looked at 3 records and whilst we found evidence that checks had been carried out in secondary care, these had not been downloaded to the patient record. This meant the clinician did not have all information available to them when reviewing patient care.

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.
- 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.
- 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

- Patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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) (NHS England and Improvement)	53	58	91.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	71	74	95.9%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	69	74	93.2%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	71	74	95.9%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	58	69	84.1%	Below 90% minimum

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

Any additional evidence or comments

The practice was aware they had not met the WHO (World Health Organisation) immunisation target for children aged 5 who have received immunisation for measles, mumps and rubella. They had regular contact with families to encourage better uptake of the immunisation. All other indicators had reached over 90% and in two areas had exceeded the WHO target.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	71.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.9%	60.2%	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)	65.3%	69.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	31.4%	64.8%	55.4%	Tending towards variation (negative)

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
<p>We saw unverified data provided by the practice that indicated the current levels of Cervical screening had improved. We saw the screening rate was 75% for the younger age group (25 to 49) and 78% for the older age group (50 to 64).</p> <p>The practice told us staff nursing shortages had made improvements to the uptake rates more difficult, however a new nurse who recently started was carrying out screening.</p>

Monitoring care and treatment

The practice had a 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

Effective staffing

The practice was unable 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.	Partial
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.	Y
Explanation of any answers and additional evidence:	
<p>We were unable to see any evidence of clinical supervision in place for staff at the practice. We were told that staff had support from colleagues and were able to discuss concerns with the management team. The practice had 'huddles', an operational/general meeting at the beginning of each day and monthly clinical meetings. Appraisals were in place and staff felt they had the opportunity to participate in this process.</p> <p>We looked at the files for 6 members of staff and 4 of these did not contain evidence of an induction to the practice. One had a framework and induction flowchart that had been signed off by the staff member. Another record was incomplete.</p>	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Partial
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:	
We were not assured that the practice was consistently identifying patients at risk of developing a long-term condition, for example diabetes.	

Consent to care and treatment

The practice 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

Caring

Rating: Good

Kindness, respect and compassion

Staff treated with kindness, respect and compassion.

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

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	88.1%	86.4%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	86.0%	85.4%	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)	94.9%	95.2%	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)	79.4%	73.6%	72.4%	No statistical variation

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

Any additional evidence

The practice did not have a formal system for carrying out surveys, however they collated feedback through their website and feedback in person. We saw a summary of this feedback between June 2021 and September 2022 totalling 16 responses. Eight of these responses were compliments about the care received by patients, how they were treated and timely access to the service.

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:	
Information and leaflets were available to patients and carers. Staff could signpost patients to other services for support.	

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	96.0%	92.1%	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

Carers	Narrative
Percentage and number of carers identified.	The total number of registered carers was 160, which was 2.6% of the practice population.
How the practice supported carers (including young carers).	The practice offered information and signposting to other organisations that could provide additional support to carers.

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:	
We observed doors being closed during consultations, privacy screens/curtains were in place and staff understood the importance of maintaining the privacy and dignity of patients.	

Responsive

Rating: Requires improvement

At this inspection, we found that the practice requires improvement for providing responsive services. This was because complaints were not always managed in a timely and appropriate way.

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.	Y
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

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:30 to 18:00
Tuesday	08:30 to 18:00
Wednesday	08:30 to 18:00
Thursday	08:30 to 18:00
Friday	08:30 to 18:00
	A telephone line is available for medical advice between 08:00 to 08:30 and 18:00 to 18:30 each day.

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none">• 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.• There was a medicines delivery service for housebound patients.• 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 able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had received feedback on access to appointments. They were reviewing the current systems for managing telephone calls and this included the introduction of a new call handling system to improve patient experiences.</p> <p>The practice had experienced significant shortages across their staff team. The provider had introduced a remote consultation service to support the practice and improve patient access. The impact of this service could not be evaluated at this stage.</p> <p>At the time of the inspection we reviewed the appointment availability. It was not possible to fully understand how the appointments were monitored and reflected patient need. We were provided with further information following the inspection to demonstrate appointment availability and usage. For example, for the period of 10/10/22 to 16/10/22 the practice data indicated the availability of 1106 appointments 'at the practice' with 659 (60%) of these booked. A further 264 telephone appointments were also available and 257 (97%) of these had been booked. The data provided did not break down the figure further to understand types of appointment. We also noted that in this period there were 64 face to face appointments where the patient did not attend.</p> <p>Following the inspection, the provider told us they had reviewed the skill mix of staff including the provision of advanced clinical roles to maximise the number of appointments offered to patients. This was to ensure patients could be seen within a timely manner. We were told that the skill mix ensured the practice always had a minimum GP capacity to provide leadership and supervision.</p>	

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG 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)	69.6%	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)	67.2%	56.3%	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)	57.9%	54.1%	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)	75.6%	75.0%	71.9%	No statistical variation

Listening and learning from concerns and complaints

Complaints were not always listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	17
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	2

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence:	
We were provided with a spreadsheet recording the complaints received in the last 12 months.	

We found that actions taken to respond to complaints were not always appropriate and timely. We saw a record of a complaint received by the practice in May 2022 and logged on the spreadsheet noting that this required an urgent review. There was little detail on the actions taken and no evidence that this complaint had been reviewed and actioned by the practice.

Responses did not always include advice for the complainant if they were unhappy with the response from the practice, including the Parliamentary and Health Service Ombudsman (PHSO). For example, we reviewed a complaint that had received an appropriate response from the practice, however the complainant had not been advised of the next steps they could take if they were unhappy with the practice's final response. Two further complaints did have the appropriate details contained with the responses.

We saw records of staff meetings, both clinical and practice meetings. We did not see that complaints had been a standing agenda item at these forums and there was no evidence of shared learning. We noted that the clinical meeting for September 2022 now had this included in the agenda. It was also difficult to assess how learning was shared and actions reviewed, as the spreadsheet provided was incomplete.

When we discussed these concerns at the site visit the practice leaders gave an undertaking to review the complaints information held and respond to patients concerns.

Well-led

Rating: Requires improvement

At this inspection, we found that the practice requires improvement for providing well-led services because:

- Governance arrangements had not ensured health and safety risks, complaints and significant events were managed well.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high quality sustainable care. However, this was not always evident.

	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.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
Feedback from staff was positive in most instances. The practice had undergone significant changes moving from one provider to another and this was during the pandemic bringing significant disruption to the normal routines of the practice.	
The leaders provided information to the Care Quality Commission in advance of the inspection recognising areas that required improvement at the practice including senior management support and areas of governance.	

Vision and strategy

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

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

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Partial
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:	
Areas of improvement identified in the management of complaints and significant events highlighted that the responses to patients were not always completed.	

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

Source	Feedback
Staff interviews and questionnaires	<p>As part of this inspection we interviewed a cross section of staff and invited the practice team to return a confidential questionnaire.</p> <p>Responses were generally positive on practice culture and support. Staff felt they could seek and receive support from their colleagues and managers.</p> <p>Staff felt proud of the teamwork during the pandemic, managing to maintain services and support for each other.</p> <p>All staff raised concerns about the staffing levels in the practice that had impacted on services including the shortages in the nursing team and GPs. We were told that the provision of locum staff and remote working had assisted during this time.</p> <p>Most staff felt management listened to their concerns. However, we did receive feedback that staff did not always feel their suggestions for improvement received enough acknowledgement and action.</p> <p>Staff felt supported with training and development, and they were given protected time for this.</p>

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	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

Managing risks, issues and performance

The practice did not always have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	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
Explanation of any answers and additional evidence: As part of this inspection we identified areas of concern with the management of significant events, complaints, fire, and health and safety assessments. This indicated limited assurance systems had been in place to identify areas that were of concern. We noted that steps were taken during our inspection to attend to concerns raised. This included the review of health and safety, and fire assessments and updating action plans in response to these assessments. We also noted that the provider had established a team to support the practice in reviewing these shortfalls.	

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
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Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>We were told that during the pandemic the practice was unable to hold Patient Participation Group (PPG) meetings due to the members being unable to use digital systems for remote meetings. The practice had tried to arrange meetings with the PPG since July 2022 but had been unsuccessful due to ill health within the PPG team.</p> <p>The practice had tried to recruit into the PPG using text messages, adding a section about the PPG on new patient's registration forms, advertisements on their website and staff taking opportunities to ask patients if they would like to join.</p>	

The practice told us following the inspection that they had established a new PPG and the first meeting had been held.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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