

# Care Quality Commission

## Inspection Evidence Table

Swallownest Health Centre

(1-545452796)

**Inspection Date: 14 June 2023**

Date of data download: 13/06/2023

## Overall rating: Requires Improvement

We undertook an inspection of this location on 15 June 2016. We rated the practice as good overall and for the effective, responsive, and well-led key questions. We rated the caring key question as outstanding; however, rated the safe key question as requires improvement. We undertook a focused follow-up inspection on 21 June 2017 to review the safe key question, and following that inspection, improved our rating to good.

We undertook a comprehensive inspection between 11 and 15 October 2021. Following this inspection, our rating for the service had declined. We rated it as requires improvement overall and for all key questions as the practice did not have clear systems to keep people safe and not all staff had undertaken the required safeguarding training for their role. The practice did not have adequate procedures in place for the management and oversight of emergency medicines, emergency medical equipment and oxygen. The practice lacked a comprehensive and established procedure to govern the management of blank prescription forms. The practice's systems for the appropriate and safe use of medicines and the management of patients prescribed high risk medicines required review. There was not a comprehensive mandatory training programme in place, and not all staff had undertaken mandatory and recommended training as required for their role, such as basic life support, resuscitation and sepsis awareness. The practice did not have an established incident reporting process in place to ensure all categories of incidents were reported and investigated appropriately. The practice did not have effective and established processes in place for the management and monitoring of patients with long-term conditions. Feedback from patients on the care they received from the service was not always positive. The practice did not investigate complaints in line with their policy, and appointment availability and telephone systems required review. The practice did not have clear and effective processes for managing risks, issues and performance, and leaders did not always demonstrate they had the capacity and skills to deliver high quality sustainable care.

We undertook a comprehensive inspection in June 2023. Following this inspection our rating stayed as Requires Improvement overall and for providing safe, effective, and well led services. The rating for providing caring and responsive services improved to good.

This was because:

Improvements had been made in the following areas:

- Staff had completed the required level of safeguarding training.
- A system had been implemented to monitor the use of blank prescriptions.

- Emergency medicines provision and equipment had been improved.
- Staff had completed recommended mandatory training in basic life support, resuscitation, and sepsis awareness.
- Improvements had been made to the staff training programme and monitoring systems and staff had undertaken training as required for their role.
- Improvements had been made to review the care of patients with long term conditions.
- Data for 2023 showed improvement in patient satisfaction in most areas.
- Significant changes had been made to systems and processes to improve access and improvements in patient satisfaction with access were seen in the most recent survey.
- Complaints management had improved.

However, whilst some improvement had been made in most of the following areas further improvement was still required.

- Records could not be found to evidence child safeguarding concerns had been reviewed.
- Health and safety risk assessments had not been completed to ensure known risks, including those outside of their control, were mitigated as far as possible.
- Systems to check emergency medicines and equipment were not robust.
- Patients prescribed high risk medicines had not always had monitoring checks at the required intervals.
- Some incidents had not been recorded and records of investigation and action taken were not always complete.
- Evidence to show appropriate action had been taken in response to medicine safety alerts was not always recorded in patient records.
- Although some audit activity was taking place the practice had not developed a formal quality improvement process with an audit plan and where patient surveys had been completed these were not always analysed and action plans for improvement developed.

## • **Safe** **Rating: Requires Improvement**

- At the October 2021 inspection, we rated as requires improvement as the practice did not have clear systems to keep people safe and not all staff had undertaken the required safeguarding training for their role. The practice did not have adequate procedures in place for the management and oversight of emergency medicines, emergency medical equipment and oxygen. The practice lacked a comprehensive procedure to govern the management of blank prescription forms. The practice's systems for the appropriate and safe use of medicines and the management of patients prescribed high risk medicines required review. Not all staff had completed recommended mandatory training in basic life support, resuscitation and sepsis awareness. The practice did not have an established incident reporting process in place.

At the June 2023 inspection, we found improvements had been made in the following areas:

- Staff had completed the required level of safeguarding training.
- A system was in place to monitor the use of blank prescriptions.
- Emergency medicines provision and equipment had improved.
- Staff had completed recommended mandatory training in basic life support, resuscitation and sepsis awareness.

However, whilst some improvement had been made further improvement was still required in the following areas:

- Records could not be found to evidence child safeguarding concerns had been reviewed and discussed.
- Health and safety risk assessments had not been completed to ensure risks, including those outside of their control, were mitigated as far as possible and not all health and safety issues were logged on the risk register.
- Systems to check emergency medicines and equipment were not robust.
- Patients prescribed high risk medicines had not always had monitoring checks at the required intervals.
- Some incidents had not been recorded and records of investigation and action taken were not always complete.
- Evidence to show appropriate action had been taken in response to medicine safety alerts was not always recorded in patient records.

### Safety systems and processes

**The practice did not 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
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	P (1)
<p>At the inspection in October 2021, we found the provider undertook DBS checks on all staff prior to the start of their employment. However, the practice did not undertake any repeat checks or renewals and had not assessed or considered this risk. Not all staff had completed safeguarding training to required levels for their role as specified in the intercollegiate guidance.</p> <p>At the inspection in June 2023, we found:</p> <ul style="list-style-type: none"> <li>• Improvements had been made to systems to manage DBS checks. A detailed policy and risk assessment had been developed and implemented to support the decision to repeat a DBS check. Staff were now required to sign an annual declaration about any new relevant information and convictions and a monitoring system was in place to enable the manager to easily see when the declarations were due. We observed declarations were completed up to date.</li> </ul>	

- Improvements had been made to completion of safeguarding training. A policy had been developed and implemented to support the decision about the level of training staff required. The online training system enabled the provider to assign staff to the appropriate training. A system to monitor training was in place. We observed 100% achievement for all sections of safeguarding training except level 3 children and adults due to 2 members of staff long term leave.
- Multidisciplinary meetings to discuss safeguarding concerns relating to adults were previously held online but had been face to face since May 2023. Records showed vulnerable adult patients and those with complex needs were discussed, and action plans developed.
- (1) We were told safeguarding concerns related to children were discussed at team meetings and that this was a standing agenda item. However, no records could be found to show child safeguarding concerns had been reviewed and discussed.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• We reviewed staff files for two members of staff who had started employment since the last inspection. We found pre-employment checks had been completed and completed application forms and interview notes were retained. However, we observed that where there were gaps in employment there were no records to show these had been discussed with the employee. The manager told us this was discussed at interview and was able to explain the gaps, but this had not been recorded. They told us they would add the question to the interview record template to act as a prompt to record this in future.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	P (1)
Date of last assessment: 26 August 2021	Y
There was a fire procedure.	Y
Date of fire risk assessment: 15 September 2022 Rotherham council - landlord	Y
Actions from fire risk assessment were identified and completed.	Y
The practice leased the first floor of a shared occupancy building from NHS property services. Rotherham council owned the building and sublet to NHS property services. At the inspection in October 2021, we found fire warden training had not been provided and several issues for action had been highlighted to the building landlord in the fire risk assessment, but these had not been	

addressed. Managers had not received any specific training from the building landlord about the use of the fire alarm system or personal safety alarms and emergency pull cords in consultation rooms and toilets.

At the inspection in June 2023, we found:

- Fire warden training had been provided and some work to a fire door and the magnets identified at the last inspection had been completed and the practice manager had completed training on the fire panel and alarm system.
- A health and safety course for primary care managers had been completed by the practice manager.
- The practice manager had worked hard to address long standing issues relating to the building such as actioning findings on the fire risk assessment and for repairs to the heating and air-conditioning system. Many of the issues were out of their control and they had been supported by the commissioning body to work with the landlord. There was evidence the provider had referred the issues to the fire officer and were awaiting a visit.

They had not been provided with a copy of the up-to-date fire risk assessment by the landlord, but this was submitted after the inspection.

- (1) However, we found health and safety risk assessments had not been completed to ensure risks including those outside of their control were mitigated as far as possible and not all health and safety issues were logged on the risk register. For example:

Liquid nitrogen was used for cryotherapy procedures. This required staff to decant liquid nitrogen from the main storage vessel into a smaller vessel. No risk assessment for the use and handling of liquid nitrogen had been completed.

Where the heating and air conditioning was not working in some areas of the practice the landlord had provided large portable units and we saw these in use in some consulting rooms. A risk assessment had not been completed for the use of this equipment.

The provider had implemented a weekly environment health and safety check list and records showed this had been completed on 1 June 2023 and 5 May 2023, but no other records could be found. Whilst we were told there were several issues with fire doors the record for 1 June stated fire doors were in working order. We were told this was because only the fire doors in the area used by the patients at the practice were checked and the communal building area was not included in the checks. Risk assessments had not been completed where issues with the fire doors continued.

Some of the building issues were recorded on the risk register and we were told they were discussed with the GP partners. However, there were no records of the discussions or any action plan to manage the issues.

## 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.	Y
Date of last infection prevention and control audit: 31 May 2023	Y
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

## 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
<p>At the inspection in October 2021, we found there was no established process in place to cover nursing staff absences, not all staff had completed resuscitation training to appropriate levels for their role or sepsis awareness training.</p> <p>At the inspection in June 2023, we found improvements had been made:</p> <ul style="list-style-type: none"> <li>The provider had filled some vacancies although recruiting GPs had been a challenge and the recruitment process for two additional GPs was ongoing. Two GPs had been on long term leave and the provider had used an agency to provide cover with regular locums who worked specific days to ensure consistency of care. They told us there were no current nursing vacancies. The nursing team comprised of 6 practice nurses, a nurse's associate, and an advanced nurse practitioner. There was also a nurse on the practice nurse vocational training scheme (VTS).</li> <li>The provider had restructured the administration team and outsourced some work to reduce GP workload and streamlined systems and processes. They had supported this work by employing temporary staff.</li> <li>Nursing cover was provided by the VTS nurse and locum nurses where required.</li> <li>Annual face to face resuscitation training was completed in June 2022 and further training was arranged. To ensure all staff could attend the training sessions the practice had a reciprocal agreement with other practices for staff to join their sessions and the training company offered training on different days for staff to attend.</li> <li>All staff had completed sepsis training.</li> </ul>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. 1	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y

There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>At the inspection in October 2021, we found the tasks, such as test results, were not always managed in a timely manner.</p> <p>At the June 2023 inspection we found:</p> <ul style="list-style-type: none"> <li>Systems had been improved and tasks were managed in a timely manner.</li> </ul>	

### Appropriate and safe use of medicines

#### The practice systems for the appropriate and safe use of medicines, including medicines optimisation were not always effective.

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) (01/04/2022 to 31/03/2023) (NHSBSA)	0.87	1.02	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) (NHSBSA)	7.7%	5.9%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) (NHSBSA)	4.84	5.40	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	135.3‰	152.4‰	129.8‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.58	0.55	0.55	No statistical variation

Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	3.3‰	5.7‰	6.8‰	Variation (positive)
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Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	P (1)
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.	P (2)
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
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.	P (3)
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	P (4)
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
At the inspection in October 2021, we found the practice did not have adequate processes in place to manage the security of blank prescription forms and to provide adequate oversight of emergency equipment. The range and quantities of emergency medicines kept were not adequate and provision was not supported by a risk assessment. We also found significant gaps in the practice's processes regarding the management and monitoring of patients prescribed certain medicines.  At the inspection in June 2023, we found some improvements had been made as follows:	



- New electronic systems to ensure blank prescriptions could be tracked through the practice had been implemented in the week prior to the inspection. These were detailed and showed who had used the prescriptions. Previous paper records could not be located at the site visit, but copies were provided after the inspection that showed prescriptions could be tracked through the practice.

(3) The emergency medicines trolley and oxygen had been moved to ensure it was more accessible to all staff and most recommended medicines were stocked. A document entitled risk assessment was provided but this was a stock list and gave no reason why two of the recommended medicines were not provided.

The emergency medicines trolley was well organised making medicines and equipment easy to find. However, we found an electronic stock list and paper record was in place, but these were not identical for example, 1 medicine was listed on the paper record but was not the computer check list and 1 medicine expiry date was not the same on both lists.

The sharps bin on the emergency trolley was out of date. Staff told us they would change this.

(4) The defibrillator calibration test was out of date and was due in February 2023.

- We conducted a range of clinical searches on the patient record system to review the management of patients prescribed certain medicines and found patients had mostly had monitoring completed although there were some shortfalls:

- We conducted a search to identify patients prescribed a high-risk medicine used to treat autoimmune conditions. Patients prescribed this medicine required regular monitoring, usually at least every 12 weeks, to ensure any complications were identified early. We identified 72 patients prescribed this medicine and identified 11 patients who were highlighted as not having the required monitoring in the last 6 months. We undertook a detailed review of five patients' records and saw all patients had been prescribed the medicine by another service and were under this service monitoring arrangements or had just been transferred back to the care of the practice. There was some evidence, for the 3 patients transferred back to the practice for monitoring, that the patient had been informed monitoring checks were due. We identified that test results stored on the hospital data base were not always downloaded to patient notes the provider told us they would review this.

- (1) (2) We conducted a search to identify patients prescribed a diuretic medicine used to treat heart failure. Patients prescribed this medicine required regular monitoring, usually monthly for first 3 months, then every 3 months for 1 year, and then every 6 months. We identified 53 patients prescribed this medicine and 17 who were highlighted as not having had the required monitoring. We undertook a detailed review of five patients' records and saw 4 patients had not had their 3-month review, 2 were overdue and 2 were 3 months overdue. It was not clearly recorded in records if these patients had been prompted to attend for review or if monitoring status had been checked before a repeat prescription was issued. We raised our concerns regarding the monitoring of patients on these medicines as part of our inspection. The provider explained all patients received regular invitations to book any required medicine reviews, usually through a text message with a link to this for the patient. However, we identified that the link sent with the text message would expire within 7 days so the patient would then not be able to use this. The provider told us they would investigate this.

Following the inspection, the provider told us they had reviewed this and found they were not in control of the links that expired within 7 days. However, they told us they had systems in place to ensure that they repeated the invitations where required. The messages sent with the link attached provided alternative options such as calling the practice to schedule an appointment. They also told us that as from the 1 September 2023 funding had been provided by the commissioners for an additional service which would also send reminders to patients if they hadn't responded to the first request.

- We reviewed the storage of medicines requiring refrigeration. Daily temperatures of the fridges were recorded online. Data loggers were also used in the fridge's but there was no evidence the data was routinely downloaded and cleared or checked for any indication of temperatures which would be outside of the recommended range and the length of time of the temperature excursion. This had impacted on an incident where the internal fridge thermometer was recording out of range temperatures and the data logger did not record the information as the memory was full. After the inspection evidence was provided

to show an investigation had been undertaken and learning had been identified. Training in the use of data loggers had been provided for relevant staff.

We saw from incident records there had been an incident where the fridge temperatures had been out of range and the practice had taken action to ensure patient safety. However, the records of the incident and the stock records did not clearly show what had happened to the medicines. Following the inspection, the practice manager provided evidence that they had completed a further investigation into the incident and learning had been identified.

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

**The practice learned and made improvements when things went wrong but the system was not always effective.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	P (1)
Staff knew how to identify and report concerns, safety incidents and near misses.	P (1)
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	16
Number of events that required action:	16
<p>At the inspection in October 2021, we found incidents were not closed in a timely manner and some categories of incidents were not reported or investigated, as specified in the provider’s incident reporting policy.</p> <p>At the June 2023 inspection we found:</p> <ul style="list-style-type: none"> <li>(1) There had been some wider reporting and incidents had been closed in a timelier manner. However, there were some incidents that had not been recorded and records were not always complete. For example, in one incident relating to storage of vaccines, actions taken had not been fully recorded and new issues relating to vaccine fridges, fire doors, central heating and air conditioning failures had not been recorded.</li> </ul>	

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

Event	Specific action taken
Prescription errors relating to monitored dosage systems	Staff training provided. Reminders put onto patient notes. Prescription checking system put in place.
Blank prescriptions left in a room by locum staff.	New procedures in place for reception staff to check rooms used by locum staff at the end of each day.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>At our inspection in October 2021, we found the practice had an established process for cascading and acting on safety alerts.</p> <p>At the inspection in June 2023, we conducted searches to review patients prescribed medicines highlighted in safety alerts we found:</p> <ul style="list-style-type: none"> <li>• (1) There were 6 patients over 65 years of age prescribed a medicine for depression above the recommended dose. We reviewed 5 patient records in detail and found the practice had discussed the risks and had programmes in place to reduce use. Records did not always show the detail about what the risks were and an electrocardiogram (ECG) to monitor cardiac risk was not routinely undertaken.</li> <li>• There were 63 patients prescribed medicines that may cause birth defects. We reviewed 2 of these patients in detail and found medicine reviews had been undertaken but discussions about the risks and contraception were not always recorded.</li> <li>• The advanced nurse practitioner had been completing regular audits of some areas of prescribing relating to medicines safety alerts.</li> </ul>	

## Effective

## Rating: Requires Improvement

At the October 2021 inspection, the practice was rated as requires improvement as the practice did not have effective and established processes in place for the management and monitoring of patients with long-term conditions. There was not a comprehensive mandatory training programme in place, and not all staff had undertaken mandatory and recommended training as required for their role.

At the June 2023 inspection we rated the practice as requires improvement because:

Improvements had been made as follows:

- Improvements had been made to the staff training programme and monitoring systems and staff had undertaken training as required for their role.
- Improvements had been made to review the care of patients with long term conditions.

However,

There was limited monitoring of the outcomes of care and treatment because:

- Although some audit activity was taking place the practice had not developed a formal quality improvement process with an audit plan.

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

### Effective needs assessment, care and treatment

**Patients' needs were assessed but 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.	P (1)
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	P
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the October 2021 inspection we found consultations were completed to a high standard and encompassed the patients' needs. However, we noted not all patients had received a regular review of their condition, treatment and/or medicines.</p> <p>At the June 2023, inspection we found:</p> <ul style="list-style-type: none"> <li>(1) Although some improvements had been made, some patients were not being reviewed in relation to their medicines as per national guidance.</li> </ul>	

### Effective care for the practice population

Findings
<ul style="list-style-type: none"> <li>The practice had systems for ensuring children and patients received vaccinations and immunisations in accordance with the recommended schedules. This included vaccinations for influenza, meningitis, and other illnesses.</li> </ul>

- Patients could access annual health assessments and health checks, which included assessment of patients' physical, mental and social needs.
- The practice assessed and monitored the physical health of people with poor mental health, which included dementia.
- Patients were referred to specialist services, where appropriate.
- The practice maintained registers of patients who may require further support, such as patients with learning disabilities, patients identified as carers and patients with certain conditions.
- 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 employed a social prescribing link worker, who linked with community groups, local authorities and voluntary organisations to support patients in seeking and accessing services.
- The practice employed a case management nurse to support patients with a long-term condition and/or frailty.
- The practice provided a health screening kiosk in the waiting area. The kiosk enabled patients to answer health questions from a library of care pathways, such as medicines reviews, NHS health checks and menopause assessments, and take vital signs measurements independently of a clinician. Results were integrated into the patient record. The system had been promoted through the practice newsletter and data showed slowly increasing numbers of patients using the service.

## Management of people with long term conditions

### Findings

At the October 2021 inspection we found the practice had some systems in place to monitor and review patients with certain long-term conditions, but this process required improvement to ensure all patients received appropriate and safe monitoring of their condition.

At the June 2023 inspection we found improvement to review the care of patients with long term conditions from our clinical searches:

- We conducted a search to review the management of patients diagnosed with asthma, particularly where patients had suffered one or more acute exacerbations of their condition. Our search identified 91 patients who had asthma and had been prescribed 2 or more courses of rescue steroids within the last 12 months. We undertook a detailed review of 5 patient records and saw steroids had been prescribed for their asthma. We saw good clinical consultation records and while patients had not been followed up by the practice within seven days of the exacerbation as per national guidance, all had been given advice to ensure they were adequately supported and were aware of when to seek further advice. We identified 4 of the 5 patients had received an asthma review within the last 12 months. We saw 1 of the 5 patients prescribed steroids had not had the required steroid card issued, which provided patients and healthcare professionals with instructions to manage their condition in the event of an emergency. The provider told us to further improve this area they now referred patients to the advanced nurse practitioner following an acute episode so they can call them within a week of treatment and give steroid cards to patients where required. They also said they had implemented a code on the patient record systems to highlight those requiring an acute asthma review.
- We conducted a search for patients diagnosed with hypothyroidism (an underactive thyroid gland) and identified 15 patients who had not received appropriate monitoring tests within the last 18 months. We undertook a detailed review of 3 patient records and saw all 3 patients had been issued with a prescription within the last two months. We identified one patient was overdue monitoring, but they were newly

registered at the practice and the practice were aware of the 2 other patients who were overdue and had taken steps to address this.

An audit had been completed to check patient compliance with their medicine regime and reviews. The practice had taken appropriate action to address any issues identified such as contacting patients for review and limiting reauthorisations of repeat prescriptions if reviews were due.

- We conducted a further search to identify patients diagnosed with diabetic retinopathy, a complication of diabetes caused by high blood sugar levels. We identified 72 patients whose last blood sugar test showed high sugar levels. We undertook a detailed review of 3 patient records and saw 2 patients were overdue review, however, these patients had frequently not attended the appointments made for them.
- A search related to chronic kidney disease (CKD) identified patients with CKD stages 4-5 who had not had appropriate monitoring tests within the last 18 months. Our search identified 9 patients, from which we undertook a detailed review of 3 patients. We noted these patients were receiving this care and treatment from their local acute hospital.

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)	158	160	98.8%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	163	167	97.6%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	163	167	97.6%	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)	162	167	97.0%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	169	180	93.9%	Met 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 had continued to perform well in provision of childhood immunisations, and we noted an increase in uptake in four of the five indicators on childhood vaccinations and immunisations.

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)	78.1%	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)	75.4%	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). (12/31/2022 to 12/31/2022) (UKHSA)	77.9%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	64.2%	51.0%	54.9%	No statistical variation

#### Any additional evidence or comments

The practice performed above the England average on the percentage of female patients aged 50-70 screened for breast cancer and the percentage of patients aged 60-74 screened for bowel cancer, as detailed in the indicators above. The practice was slightly below the 80% target on the percentage of women who had been adequately screened for cervical cancer and we noted this was slightly down at 77.9% from 79.4% in March 2021.

#### Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	P (1)
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
At the October 2021 inspection we found the practice had conducted some clinical audits. An established quality improvement process was not in place and the practice was not participating in any local or national clinical pilots or other initiatives.	

At the June 2023 inspection we found:

- The practice had not developed a formal quality improvement process with an audit plan. The practice undertook clinical audits on an ad hoc basis or as part of the medicine’s incentive scheme.

Samples of 4 audits were provided.

- The first audit related to confirming insulin doses and updating the instructions on prescription. This had been completed by the pharmacist between April 2022 and March 2023. At the start of the audit 185 patients were identified for review. In September 2022 16.1% had been reviewed and this had increased to 26.2% in December 2022. Final data collection showed 79.4% of patients had their repeat prescription updated with insulin doses although 2 patients were specified on the list twice and this would indicate the 80% target was achieved.
- The second audit completed by the pharmacist looked to switch a medicine prescribed for chronic obstructive airways disease to improve patient compliance, simplify regimes and ensure cost effective prescribing. 36 patients were reviewed and in agreement with the patients all but 5 had their prescription changed.
- The third audit aimed to review patients on both epilepsy and thyroid medication that have not requested repeat prescriptions in 3 months. It was identified at the start of the audit that 28 patients would benefit from the review. Patients on the list were contacted to attend for any outstanding blood monitoring and to clarify why medication had not been requested. The final data collection in March 23 all patients had been reviewed and 10 patients had been identified for further follow up.
- An audit to look at prescribing for urinary tract infections had been undertaken by the advanced nurse practitioner. The first data collection, December 2021 to January 2022, showed 100% compliance with prescribing antibiotics only 31% of patients were treated according to national guidelines due to shortfalls in areas such as recording symptoms and length of treatment prescribed. Learning and guidelines for treatment had been shared. A second data collection September 2022 to October 2022 showed 40% had been treated according to national guidelines, again learning had been shared and further audit was to be scheduled.

The practice had been involved in the NHSE Accelerate programme since August 2022. This involved engaging with staff and NHSE and other practices nationally to help them to understand their data and make improvements to the management of tasks, prescriptions, appointments, communications and reviewing process/protocols. The provider told us this had enabled them to streamline their processes.

### Effective staffing

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

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



There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>In October 2021 we found not all staff had completed all mandatory training modules and the practice's mandatory training programme did not include all key topics as recommended or required for each staff members' role. We also found not all staff had received an appraisal within the last 12 months.</p> <p>At the June 2023 inspection we found:</p> <ul style="list-style-type: none"> <li>• A training programme was provided online, and the system enabled the provider to easily monitor training. We saw improvement in training completion in areas such as resuscitation training.</li> <li>• The training modules provided did not include learning disability and autism training. Since 1 July 2022, all registered health and social care providers have been required to provide training for their staff in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability at a level appropriate to their role. Following the inspection, the provider told us this training had been organised with the mental health service on 30 May 2023 and training was scheduled for 22 June 2023 in line with learning disability awareness week. They told us they were also in discussions with their training provider to access additional recognised training in this area.</li> <li>• We observed staff were up to date with their appraisals except for two staff, one which was scheduled and another which could not be scheduled but a reasonable explanation was given for this. Appraisals were recorded on the practice electronic record this enabled the provider to easily monitor completion.</li> <li>• Staff told us there had been lots of changes to support staff and mentorships and buddy systems had been introduced.</li> <li>• Systems were in place to support staff and monitor competence. One of the non-medical prescribers told us they had a weekly recorded mentorship discussion which included prescribing with a GP.</li> </ul>	

## Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<ul style="list-style-type: none"> <li>• There were systems and processes in place to ensure test results, documents and referrals were actioned promptly.</li> </ul>	

### Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice employed a social link worker, who proactively worked with community organisations and voluntary groups to enable patients to access tailored help and support.</li> <li>The practice had recently employed a case management nurse to support patients with a long-term condition and/or frailty. The nurse supported patients to minimise the risk of hospital admission and they visited to patients who were unable to attend the surgery.</li> </ul>	

### Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<ul style="list-style-type: none"> <li>All staff had completed mental capacity and deprivation of liberty training.</li> <li>We reviewed 2 records for patients who had a DNACPR in place. We observed 1 patient had had their DNACPR put in place by another service. We could not see that there was a copy of the form saved on the patients records. However, the records showed the decision had been reviewed by the GP during a home visit.</li> </ul>	

## Caring

## Rating: Good

At the October 2021 inspection, the practice was rated as requires improvement as feedback from patients was not always positive.

At the June 2023 inspection we rated the practice as good for providing caring services because:

- Data showed improvement in patient satisfaction in most areas.

### Kindness, respect and compassion

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

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

Patient feedback	
Source	Feedback
CQC Give Feedback on Care	In the 12 months prior to our inspection period, CQC had received 18 complaints and 3 positive feedback submissions. Most of the complaints related to difficulty making appointments. The practice had implemented several improvements to address the complaints.
Patient complaints from information provided by the practice.	In the 12 months prior to our inspection period, the practice had received 26 complaints from patients and their families. Of the 26, 10 complaints related or referred to staff attitude. The practice had taken action to improve and in response had provided training in care navigation, assertiveness, communication, and conflict resolution.

### 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	86.5%	84.2%	84.7%	No statistical variation

professional was good or very good at listening to them (01/01/2022 to 30/04/2022)				
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)	78.6%	82.3%	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)	97.9%	92.6%	93.1%	Tending towards variation (positive)
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)	62.5%	70.3%	72.4%	No statistical variation

### Any additional evidence or comments

The practice performed in line or above England and local averages for the above indicators in early 2022.

Surveys undertaken in early 2023 were published after the inspection had taken place and showed improvement as follows:

- From 86% to 91.6% for healthcare professional being good or very good at listening to them.
- From 78.6% to 83.5% for the healthcare professional being good or very at treating them with care and concern.

There was a very slight drop in satisfaction for patients having confidence and trust in the health care professional from 97.95 to 95.8% and in those who responded positively to the overall experience of their GP practice from 62.5% to 61.9%.

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

### Any additional evidence

The practice manager told us there had been no in house patient survey this year due to having to undertake a survey about boundary changes which was imminent.

The Primary Care Network (PCN) had produced a patient survey for all the practices in their area and this showed that the main barriers to care was related to access.

The practice told us surveys were sent to patients every month for some local enhanced services; results were sent to the commissioners the integrated care board (ICB). The data for the surveys from June 2022 to November 2022 was provided after the inspection and showed there had been 943 responses of which most patients indicated they were either satisfied or very satisfied. Of the few dissatisfied patients comments related in the main to the phlebotomy and wound care services. We didn't see any evidence of a formal analysis to identify learning or action plan for improvement developed from survey results.

The practice shared survey results with the patient participation group.

### Involvement in decisions about care and treatment

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

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

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	96.3%	89.0%	89.9%	Tending towards variation (positive)

### Any additional evidence or comments

The practice performed above England and local averages for the above indicators in early 2022 and had improved from 96% in 2021.

The results from the National GP Patient Survey, undertaken in early 2023, were published after the inspection. This showed there had been a slight drop in patient satisfaction from 96.3.% to 92.6% but were still above local and national averages.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: At the October 2021 inspection we found all patient leaflets and booklets had been removed because of COVID-19 and staff posted out leaflets to patients if required.	

At the June 2023 inspection we found information boards and leaflets were now available to patients in the waiting areas.

Carers	Narrative
Percentage and number of carers identified.	<p>The practice had increased identification of carers from 286 patients in October 2021 to 399 in June 2023 and from 2 to 5 patients as young carers. From a total patient population of 16,200, this equated to a percentage of approximately 2.4%.</p> <p>The practice had information for carers to complete on registration.</p>
How the practice supported carers (including young carers).	<p>The practice maintained registers of patients identified as carers or young carers. Dedicated information to support carers was available on the practice's website, which included links to types of help and support available to carers, as well as information on financial and legal help.</p>
How the practice supported recently bereaved patients.	<p>The practice employed a social link worker and care coordinator who provided care and support to recently bereaved patients.</p> <p>The practice had systems to notify all practice staff and the patients usual GP would contact the patient.</p>

**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
<ul style="list-style-type: none"> <li>• The practice had several rooms across the building, which patients could use to discuss sensitive or confidential matters with staff.</li> <li>• When patients arrived for appointments, patients could check in using an electronic screen, which enhanced confidentiality.</li> <li>• Protective screens were present at all reception desks, which prevented patients and visitors from viewing personal information on computer screens.</li> </ul>	

**Responsive**

**Rating: Good**

At the October 2021 inspection, the practice was rated as requires improvement as appointment availability and telephone systems required review, and the practice did not resolve or investigate complaints in line with their policy.

At the June 2023 inspection we rated the practice as Good for providing responsive services because:

- Significant changes had been made to systems and processes to improve access.
- Improvements in patient satisfaction with access were seen in the most recent survey.
- Complaints management had improved.

### 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
<p>At the October 2021 inspection we found the reception desk located in the corner of one of the waiting areas. Although this provided a good view of one of the waiting areas, we noted there was poor visibility of the other waiting area due to the staircase blocking the view.</p> <p>At the inspection in June 2023, we found:</p> <ul style="list-style-type: none"> <li>• The provider had conversations with council about visibility of the waiting area and a mirror had been installed to try to help this.</li> <li>• At the inspection in October 2021 the practice had introduced several digital and online tools to support patients to access care. Results in the National GP Patient Survey published after the June 2023 inspection showed these improvements were beginning to have some impact on patient satisfaction with access.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6.30pm
Tuesday	7am – 6.30pm
Wednesday	8am - 6.30pm

Thursday	8am-6.30pm
Friday	8am-6.30pm
Appointments available:	
Monday	8.30am - 8.30pm
Tuesday	7am - 6.30pm 6.30pm – 8.30pm Pharmacist telephone appointments only. Building not open.
Wednesday	8am - 8.30pm
Thursday	8am - 6.30pm
Friday	8am - 6.30pm 6.30pm – 8.30pm
	An extended access service started 2 June 2023 and was provided by Connect Health. The building was open only for pre-booked appointments. Entry was via an intercom

#### 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 appointments for those with enhanced needs and complex medical issues.
- The practice operated an extended hours service, which allowed patients to attend appointments from 7am to 8.30pm. This included appointments with GPs and nurses.
- The practice held a register of patients living in vulnerable circumstances, which included patients with a learning disability, and adjusted the delivery of its services to meet patients' needs.
- People in vulnerable circumstances were easily able to register or obtain care from the practice, which included patients with no fixed abode. This included access to vaccinations and immunisations.
- The practice had responsibility to provide care for one large care home in the local area. The practice had a care home lead GP who completed a ward round on a Tuesday and in their absence another GP would attend. The practice provided a dedicated phone number for the care home to contact the practice. They also provided care for two smaller homes of 5/6 beds for patients with a learning disability. Another GP was responsible for these homes and visited the home when required. The advanced nurse practitioner or physician associates also visited as required.

#### Access to the service

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

Y/N/Partial



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

At the inspection in October 2021, patient feedback and practice performance data showed patients were not always able to book appointments when they required it and did not always find it easy to contact the practice, particularly by telephone.

At our inspection in June 2023, we found the practice had implemented several new initiatives to improve access:

- The practice offered a range of appointment types, which included telephone consultations, video consultations and face-to-face appointments.
- Appointment requests were triaged by reception staff using the Care Navigation template to assess needs or signposted accordingly to the most appropriate service.
- A new telephone system had been purchased. This enabled the provider to monitor call handing and showed information such as calls waiting and length of time a call had been waiting. They had been set a target to answer calls within 10 minutes by the commissioners and had upskilled staff to enable more people to answer the phones at busy periods. All staff could see the board, and this allowed them to work as a team to answer calls.
- The practice had accessed the NHS accelerate programme to review and improve access and the on-call system.
- The practice had 7/8 GPs available on the day and patients could prebook an appointment up to 2 weeks ahead. They provided book on the day appointments, some of which opened at 1pm and others open late afternoon for access for the following day.
- Patients could book some appointments online, apart from GP appointments as the provider had found these were being booked inappropriately.
- In March 2023, to improve continuity of care, they had implemented links to book appointments. This enabled the practice to send patients a text message with link to book an appointment where they needed to have a follow up.
- The practice also provided one sit and wait appointment per GP on duty.
- Improved results in the GP patient survey, published after the June 2023 inspection, showed these improvements were beginning to have some impact on patient satisfaction with access.

### **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 (01/01/2022 to 30/04/2022)	18.2%	N/A	52.7%	Significant variation (negative)
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)	37.5%	52.3%	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)	38.7%	51.4%	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)	58.7%	67.6%	71.9%	No statistical variation

#### Any additional evidence or comments

At our inspection in October 2021, we found the National GP Survey results been sharp decline in performance from the 2020 survey, where the practice had achieved 79.9%. Managers attributed this decline to several factors related to COVID-19.

At the inspection in June 2023, we found some improvement:

- There had been continued decline in patient satisfaction at the time of the 2022 National GP Survey results above. However, following the June 2023 inspection the most recent GP survey results were published for the period January to March 2023. These showed a slight improvement across all the above areas although three areas were still below local and national averages. This included patient satisfaction as to how easy it was to get through to the GP practice by telephone which had improved from 18.3% in 2022 to 27.8% in 2023, national average was 54.4%. Satisfaction with the appointment they were offered showed the most improvement and was now above local and national averages and had improved from 58.7% to 80.5%, national average was 72%.
- The practice had implemented several initiatives to improve access which included a new telephone system, upskilling staff to enable more people to answer the phones at busy periods and online appointment booking.
- The provider told us the low patient satisfaction results were partly due to a significant turnover of reception staff which had impacted the reception team. They told us they had reached out to other organisations for assistance during this period with little effect and existing staff had assisted by working additional hours during the recruitment. They told us had also had an increase in the volume of calls in December 2022 and January 2023 due to an increase in concerns about a Strep A infection.

Source

Feedback

NHS.uk website (formerly NHS Choices)	Mixed feedback some positive comments about access and care and treatment
CQC – patient feedback	CQC had received 20 complaints in the last 12 months, 10 of which related to access.

### 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.	26
Number of complaints we examined.	26
Number of complaints we examined that were satisfactorily handled in a timely way.	26
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>At the inspection in October 2021, we found complaints were not adequately managed.</p> <p>At the inspection in June 2023, we found:</p> <ul style="list-style-type: none"> <li>Complaints were now managed and monitored through the practice electronic management system. This showed all the complaints, apart from 1 which was still under investigation, had been responded to and action points identified. Complainants had received a response which included escalation procedures. Learning points were recorded and available for all staff. An annual meeting to discuss complaints was to be scheduled.</li> </ul>	

Complaint	Specific action taken
Concern re lack of continuity of care and staff attitude.	Contacted patient and safety net advice given for condition. Appointment booked with GP. Reviewed staff rotas. Staff training provided.
Patient not satisfied with their care and management of prescription.	Discussion with reception staff about checking patients nominated pharmacy and with GPs about the required times for samples to be provided so they can be processed.

## Well-led

## Rating: Requires Improvement

At the October 2021 inspection, the practice was as requires improvement as the practice did not have clear and effective processes for managing risks, issues and performance, and leaders did not always demonstrate they had the capacity and skills to deliver high quality sustainable care.

At the inspection in June 2023, we rated the practice as requires improvement because:

- Whilst we saw improvement in many areas some processes were not fully embedded, and systems were not always used to their full potential.
- A risk log was in place, but this did not identify all risks and there were no action plans for improvement or to manage risk.
- There had been improvement in most areas and the provider had taken part in improvement programmes. However, there was no formal plan for improvement.
- Where surveys had been completed these were not always analysed and action plans for improvement developed.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>At the inspection in October 2021, we found the practice was undergoing a transition period and was in the process of implementing several new systems and procedures however, these were not fully embedded at the time of inspection. The practice had a high staff turnover rate. Leaders did not always demonstrate they understood the challenges affecting the practice and did not always identify the actions required to address these.</p> <p>At our inspection in June 2023, we found:</p> <ul style="list-style-type: none"> <li>• The practice were in the process of implementing systems to support processes. For example, they had improved some processes using an electronic system which enabled the practice manager and provider to easily monitor data and share information. This had been well implemented for some areas, such as staff training, but areas such as risk management had not been fully implemented to ensure effectiveness. They told us they had had a high turnover of staff which had delayed the work on this.</li> <li>• They told us they had mostly filled vacancies although recruiting GPs had been a challenge and the recruitment process for two additional GPs was ongoing. Two GPs had been on long term leave and the provider had used an agency to provide cover with regular locums who worked specific days to ensure consistency of care. There were no current nursing vacancies. The provider had restructured the administration team and outsourced some work to reduce GP workload and streamlined systems and processes. They had supported this work by employing temporary staff.</li> </ul>	

- We saw some improvement in most areas, but some systems were not fully embedded, and some required further improvement to ensure improvement would continue and be sustained. For example, a risk log was in place on the electronic practice management system which identified the level of risk but other than the entry on the log there are no action plans for improvement or to manage risk or progress reports. The log did not identify all risks and there were no action plans for improvement or to manage risk. Records for incident management were in place but some incidents had not been recorded and records of investigation and action taken were not always complete.

### 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
At the October 2021 inspection we found the practice was in the process of developing its mission statement and vision for the future.  At the June 2023 inspection we found: <ul style="list-style-type: none"> <li>• The vision statement had been developed and was displayed on the practice website.</li> </ul>	

### Culture

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

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

At the October 2021 inspection we found not all staff had completed equality and diversity or duty of candour training and contact details of the Freedom to Speak Up Guardian were not provided.

At the inspection in June 2023, we found:

- Equality and diversity training formed part of the provider’s mandatory training programme and staff had completed this training.
- Training records showed staff had received training on meeting the requirements of duty of candour.
- The practice whistleblowing procedures had been updated with the Freedom to Speak Up Guardians contact details.

**Governance arrangements**

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<ul style="list-style-type: none"> <li>• The practice had governance structures in place, and both staff and managers were clear of their roles and responsibilities.</li> <li>• The practice was trying to reduce use of paper records where possible and had implemented an electronic practice management system to assist this. We observed the recruitment records were held in several different places, with some in several different electronic files and some in paper files for each member of staff. This may create difficulty locating records in future if key members of management staff were to leave the practice. The practice manager recognised this and said they would review the system.</li> </ul>	

**Managing risks, issues and performance**

**The practice did not 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.	P (1)(2)
There were processes to manage performance.	P (1)
There was a quality improvement programme in place.	P (1)(2)
There were effective arrangements for identifying, managing and mitigating risks.	N (1)
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>At the October 2021 inspection we found the practice did not have comprehensive or effective assurance systems in place, and risks were not always identified, mitigated, or managed appropriately. Although some improvements were made, there was not an established and comprehensive quality improvement programme in place.</p> <p>At the inspection in June 2023, we found:</p> <ul style="list-style-type: none"> <li>• (1) A risk log was in place on the electronic practice management system which identified the level of risk but other than the entry on the log there are no action plans for improvement or to manage risk or progress reports. The log did not identify all risks and there were no action plans for improvement or to manage risk.</li> <li>• (1) Some incidents had not been recorded and records of investigation and action taken were not always complete'</li> <li>• (1) There was evidence the practice manager had been proactive in addressing issues with the landlord relating to fire doors, heating and air conditioning, however, the risk log had not been updated and there was no risk assessment to identify the risk to patients and staff or an action plan to mitigate risk. There was no evidence these risks had been discussed in meetings with the provider.</li> <li>• (2) There had been improvement in most areas and the provider had taken part in improvement programmes, for example, to improve access. However, there was no formal overall plan for improvement.</li> </ul>	

**Appropriate and accurate information**

**Data and information was not used proactively to drive and support decision making.**

	Y/N/Partial
Staff used data to monitor and improve performance.	P (1)
Performance information was used to hold staff and management to account.	P (1)
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>At the October 2021 inspection we found the practice had invested in several digital tools to enhance their performance, however, performance data provided by these tools was not always monitored or used to drive improvements.</p> <p>At the June 2023 inspection we found:</p>	

- The practice had continued to slowly implement the use of their electronic systems and had implemented several new processes. Whilst we saw improvement in many areas some processes were not fully embedded, and systems were not always used to their full potential.
- Where surveys had been completed these were not always analysed and action plans for improvement developed.

### Governance and oversight of remote services

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

### Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>The practice had an active patient participation group (PPG), who worked with the practice to improve services for patients. The practice sought the views of patients when planning services or making changes to the practice. The work of the PPG was advertised within the practice.</p> <p>The practice manager attended local Primary Care Network (PCN) meetings.</p>	



Feedback from Patient Participation Group.

Feedback
<p>The PPG chairman told us that the PPG group had grown and had 10 members from different patient groups.</p> <p>They told us they met bimonthly and had been involved with a recent survey about boundary changes. The practice manager and care coordinators attended the meetings. They said they also attended the local Primary Care Network (PCN) PPG meetings.</p> <p>They said the last CQC inspection report had been shared with them and there had been some positive changes. For example, the telephone system, types of appointments offered, and times of appointments had all been improved.</p> <p>They told us to reduce the incidence of missed appointments, which they felt was due to patients not being able to get through on the phone, the system to cancel appointments had been improved and an answer phone had been implemented so patients could leave a message to cancel.</p> <p>They felt the changes had had a positive impact for patients and there seemed to be less negative chat about the practice on social media platforms.</p>

**Continuous improvement and innovation**

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	P
Learning was shared effectively and used to make improvements.	P
<p>At the October 2021 inspection we found the practice had invested in several digital and technology services. However, there was not an established process in place that focused on the wider continuous improvement and innovation of the service.</p> <p>At the June 2023 inspection we found:</p> <ul style="list-style-type: none"> <li>• The practice had continued to implement electronic management systems to reduce the use of paper records but some of these systems were not fully embedded or used as effectively as they could be. Some of this work had been delayed due to staffing shortages but vacancies had now been filled.</li> <li>• Clinical audits had been undertaken, by the pharmacist or nurse, but there was no clinical audit plan to support this work.</li> <li>• Surveys were sent to patients every month for some local enhanced services; results were sent to the commissioners the integrated care board (ICB). We didn't see any evidence of a formal analysis to identify learning or action plan for improvement developed from these survey results.</li> <li>• The practice and supported medical students and GP Registrar training. They also supported trainee nursing associates and primary care nurse training programmes.</li> </ul>	

## Examples of continuous learning and improvement

- The practice had reviewed access arrangements and had introduced several measures to improve this area.
- Since August 2022 they had taken part in the NHSE Accelerate programme. They had engaged with staff and NHSE and other practices nationally to help them to understand their data and make improvements to tasks, prescriptions, appointments, communication and reviewing process/protocols. They told us this had enabled them to streamline processes.
- They had taken part in the NHS registration pilot and the practice was informed when patient wanted to register.
- Since June 2022 they had implemented a Health screening kiosk. This enabled patients to be involved with their care and to answer health questionnaires and take their own observations, such as blood pressure which were then directly added to their patient records. If, for example the patient was recorded as having blood pressure the system sent a task to staff with an alert. The PPG trialled the system to get feedback and an action log for improvements was developed from this.
- They were working towards bronze award for Greener Practice and had implemented several measures to achieve this such as systems to enable clinicians and administrators to communicate with patients by text as well as providing video and photo functionality to phone calls.

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.