

Inspection Evidence Table

Dr Avinash Suri

(1-509917429)

Inspection Date: 21 and 26 June 2023

Date of data download: 21/06/2023

Overall rating: Good

Safe

Rating: Good

At the last focused inspection held on the 2 and 8 August 2022, we identified the provider was not providing safe care. At this time, we identified lack of evidence of appropriate systems to facilitate monitoring of work undertaken by staff (ensuring they were working to the terms of their employment and scope of knowledge), inconsistent monitoring of patients prescribed high-risk medication and patients with long-term conditions. Finally, we noted that vaccines held at the practice were kept safely and according to manufacturers' guidelines.

Following that inspection, we issued the provider with Warning Notices to ensure compliance with Regulations 12 and 17 of the Health and Social Care Act (HSCA)2008 (Regulated Activities) Regulation 2014 following the August 2022 inspection and placed the practice in special measures.

A follow-up inspection held on 18 and 25 January 2023 was undertaken to confirm that the provider had complied with the Warning Notices in relation to Regulation 12 and 17 (Regulated Activities) Regulation 2014 of the HSCA issued following the August 2022 inspection.

At this inspection held on the 21 and 26 of June 2023 (as result of the practice being placed in special measures following the August 2022 inspection), we identified that the providers had made significant improvements to their provision of safe care at the practice. The provider had established clear processes to monitor and manage risks to patient safety, was able to make improvements when things went wrong, knew what to do to keep people safe from abuse and ensured patient records were written and managed securely and in line with current guidance and relevant legislation.

As a result of the findings of this inspection, the practice is now rated good for the key question of safe.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a safeguarding multi-agency referral form for both children and adults which contained details regarding who to contact (with telephone numbers) during normal and evening working hours, and weekend referrals. Safeguarding referral and contact details were also accessible via the practice shared drive and on the local integrated care board website.</p> <p>The practice had a safeguarding lead as well as a deputy safeguarding lead, who were the two lead GPs. In addition, there was an administrative safeguarding lead.</p> <p>Staff files we checked showed staff had completed safeguarding training at the appropriate level for their role. Staff we spoke with knew what to do in the event of a safeguarding concern, and the provider had (since our last focused inspection) established a detailed written safeguarding policy for staff to refer to.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>We viewed three staff files as part of our inspection and found these files contained all relevant information. This included signed contracts references, DBS checks and a record of immunisations received.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 13 June 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: unknown	P
Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection held in August 2022, we found that the practice had not completed any health and safety or fire risk assessments during the previous 24 months.</p> <p>At this inspection, the practice was able to evidence risk assessments undertaken relating to buildings, health and safety and security. These were in-house assessments completed by the practice manager. The assessments contained several different risk ratings, but the assessments did not contain a key to explain the meanings of assigned ratings.</p> <p>There was a fire procedure in place, but there was no evidence that a separate fire risk assessment had been undertaken by the practice, except for mention of protective fire measures within the current buildings, security and health and safety assessment.</p>	

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: 13 June 2023	P
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
<p>Explanation of any answers and additional evidence:</p> <p>We checked three staff files which showed members of staff had completed infection control training undertaken during the last 12 months. The staff training matrix (provided to the inspection team by the practice) identified that staff had received appropriate training online and staff we spoke with had a good understanding of maintaining and promoting infection prevention and control. The files we viewed had records of staff immunisations or risk assessments if members of staff did not want the recommended immunisations.</p> <p>The practice had conducted a joint risk assessment which comprised of health and safety, fire and infection control. As this was a general risk, the inspection team did not identify a date when the last specific infection and prevention control audit had occurred.</p>	

The inspection team observed that rooms used for consultation and clinical purposes were tidy and clean. We viewed the cleaning log for the practice and found that this was completed to satisfactory standard.

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>Explanation of any answers and additional evidence:</p> <p>At our last inspection held in August 2022, we found the provider did not have an effective approach to managing staff absences. At this time, we identified ongoing staffing issues at the practice which had not been addressed by the provider. These issues included not arranging adequate cover for absent colleagues.</p> <p>At this inspection held on 21 and 26 June 2023, we found that the provider had addressed our concerns with reference to staffing. There was now a rota in place to ensure that there was adequate cover for staff who had arranged leave as well as possible cover for unexpected staff absences. Administrative staff told us that colleagues were often able to cover for each other at short notice.</p> <p>The practice had oxygen, a defibrillator and a selection of emergency medicines in place to assist appropriately trained staff to respond to any medical emergencies that may occur at the practice. There was a system in place to ensure that medicines kept securely at the practice (along with the oxygen and defibrillator) were checked regularly to ensure that they were fit for purpose.</p> <p>The practice reception area had a poster highlighting symptoms of sepsis and staff we spoke with were able to tell us the steps they would take if a patient contacted the practice with symptoms correlating to sepsis.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial

Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since our focused inspection in August 2022, the practice is in the process of moving from being a sole provider to a two GP partnership. As part of their review of patient care records on joining the practice, the incoming GP partner identified that work was required to ensure that all patients were getting care in a timely fashion.</p> <p>Following our August 2022 inspection, we issued the then provider with a warning notice under Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we identified that not all patient records we looked at were not always written with an adequate summary of any prescribing or consultations.</p> <p>At this inspection, we found evidence of good improvement in relation to written summaries of patient records we viewed as part of our clinical records review to assure ourselves that patient records were managed correctly to deliver safe care and treatment.</p>	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	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)	0.58	0.69	0.91	Variation (positive)
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)	9.8%	8.5%	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) <small>(NHSBSA)</small>	6.73	5.64	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) <small>(NHSBSA)</small>	46.1‰	65.4‰	129.8‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) <small>(NHSBSA)</small>	1.24	0.43	0.55	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) <small>(NHSBSA)</small>	6.1‰	5.4‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y

Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>At our August 2022 inspection, we identified areas of concern relating to the lack of timely reviews of medication for patients, lack of effective monitoring of usage of hard-copy prescriptions and no recorded supervision of the work of the advanced nurse practitioner (working as a practice nurse) and the primary care network (PCN) clinical pharmacist. In addition, we found the practice phlebotomist working outside of their scope of duties by administering of travel vaccines (typhoid) and B12 injections to patients without any written authority to do so.</p> <p>At this inspection held on the 21 and 26 June 2023, we found that the provider had put in place processes which showed improvement in the safe and appropriate use of medicines at the practice. The practice had employed a clinical pharmacist, who worked alongside the incoming GP partner and the existing PCN pharmacist to ensure that structured medicines reviews for patients on repeat medicines were undertaken according to recommend national guidelines for the prescribed medication. We looked at five patient records coded on the clinical system as having medicines reviews and found that these patients had received a recent medicines review. This was evidenced by notes added by a clinical member of staff at the practice of as part of the review.</p> <p>The monitoring of the usage of hard-copy prescriptions within the practice continued, with prescriptions still being held securely and were given to clinical staff when requested, but with the addition that there was now a record kept of the number of prescriptions used within the practice and by which member of clinical staff.</p> <p>The practice held appropriate emergency medicines. There was a system was in place to monitor stock levels and expiry dates of medicines, as well as regular checking of the medical oxygen and defibrillator to ensure these items were fit for purpose.</p> <p>We found the vaccine fridge at the practice in good working order and that products stored in the fridge were correctly stored, according to the manufacturer's instructions.</p> <p>The provider no longer employed a phlebotomist.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months: 16	Y
Number of events that required action: 12	Y

Explanation of any answers and additional evidence:

Staff at the practice we spoke with demonstrated an understanding of what a significant event was, how these were logged, assessed and how learning was identified and shared. We saw evidence (via clinical meeting minutes) that discussions were undertaken reviewing recent significant events/incidents, medicines safety alerts and complaints. Similar discussion also took place at all staff meetings.

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

Event	Specific action taken
Delayed referral as secondary care provider had not been selected by clinical staff.	Once identified that a referral had not been completed, the submission of the referral was prioritised as an urgent task by the practice. GPs tasked admin staff to add referral to add patient to safety netting spreadsheet for monitoring of follow-up. GP were reminded for future referrals to defer to a provider immediately for the patient to be placed on a waiting list.
Patient record coding	An audit of records identified where patient samples had been rejected but the patients record had not been coded accordingly. As a result of the audit, staff placed a copy of rejected sample notification on relevant patient record and a diary entry for date of next sample to be conducted.

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>Explanation of any answers and additional evidence:</p> <p>At our August 2022 inspection, the provider was unable to evidence effectively how safety alerts (current and historical) were managed within the practice. There was no evidence the practice routinely monitored patient safety alerts to ensure that they were acted upon.</p> <p>Our clinical records review held on 21 June 2023 provided evidence that the provider now had a process in place to review and respond to patient safety alerts. Staff within the practice had signed up to receive alerts when issued by various outside organizations. The incoming GP partner, alongside the in-house and PCN clinical pharmacists reviewed and responded to patient safety alerts.</p> <p>We conducted a clinical search on a historical safety alert relating to the possible risk of prescribing a specific medicine to women of child-bearing age who were taking oral contraception. Our search identified one patient who was being prescribed the specific medicine alongside oral contraception and we noted that the patient record had a record that possible risks had been discussed with this patient and that regular monitoring of this patient was being conducted by the practice.</p>	

Effective

Rating: Requires improvement

At our last focused inspection held on the 2 and 8 August 2022, we identified the provider was not providing effective care. We identified lack of evidence of patients' treatment being reviewed regularly and limited processes in place for the monitoring of patients on high-risk medicines. In addition, the provider was unable to demonstrate that they always obtained patient consent to deliver care and treatment in line with legislation and guidance. Finally, there had been a long-running data issue which meant the provider was unable to assure themselves and the inspection team of the numbers of children that had recently received childhood vaccinations according to national schedules.

We issued the provider with Warning Notices to ensure compliance with Regulation 12 and 17 of the Health and Social Care Act (HSCA)2008 (Regulated Activities) Regulation 2014 following the August 2022 inspection and placed the practice in special measures.

A follow-up inspection held on 18 and 25 January 2023 was undertaken to confirm that the provider had complied with the Warning Notices in relation to Regulation 12 and 17 (Regulated Activities) Regulation 2014 of the HCSA issued following the August 2022 inspection. and placed the practice in special measures.

At this inspection held on the 21 and 26 of June 2023 (as result of the practice being placed in special measures following the August 2022 inspection), we identified that the providers had made improvements to their provision of effective care at the practice. The providers had established processes to ensure that patients' needs, care and treatment was delivered in a timely manner, a programme of quality improvement activity had been established to review the effectiveness and appropriateness of the care provided by the practice and that staff had the skills, knowledge and experience to carry out the roles they were employed for. However, the practice uptake for both cervical screening and childhood vaccinations remained lower than the national average and World Health Organisation targets respectively.

As a result of the findings of this inspection, the practice is now rated requires improvement for the key question of effective services.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	P

Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice 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>The practice had systems and processes to keep clinicians up to date with current evidence-based practice through access online to local and national guidance. Through our discussions with clinical staff, we were provided evidence of how they were able to keep up to date with evidence base practise. For example, the practice nurse was able to describe to the inspection team guidelines that they consulted before administering vaccines to patients.</p> <p>At our last inspection held in August 2022, we found minimal evidence that the practice had embedded systems in place to ensure adequate monitoring of patients with long-term conditions. At this time, we were unable to establish from the provider details relating to the number of medicines reviews undertaken by the PCN pharmacist during 2022. In addition, we were not able to verify that all clinical staff at the practice regularly used patient registers to ensure that patients were receiving effective care and treatment.</p> <p>At this inspection, the provider had rectified these issues by conducting a thorough review of patients identified as having long-term conditions and ensuring that patient records were correctly coded to identify these patients.</p> <p>We conducted a clinical records search using the practice patient list for patients with hypothyroidism (under active thyroid) to see if patients with this condition had received a recent thyroid test and medication review. One patient was identified as a result of this search. We looked further into this record and saw that the patient despite having a thyroid test conducted within the last 18 months, did not received a medicines review in previous 12 months and there was no other evidence of monitoring of this patient on their clinical record.</p> <p>Similarly, we ran a clinical records search using the practice patient list for patients diagnosed with asthma who had been prescribed two or more courses of rescue steroids in the last 12 months. Rescue steroids for asthma are prescribed when a patient has worsening asthma symptoms and/or to prevent an asthma attack in progress from getting worse. Three patients were identified from this search, and we looked at two patient records. We found that neither patient had a clinical assessment or a date when the patient was followed up following treatment noted on their clinical records. One of the two patients had received an asthma review this year, with the second patient's review having been conducted remotely in October 2020</p> <p>A third clinical search conducted focusing on the medication Methotrexate to ascertain if the practice had completed due diligence (in terms of patient monitoring) before issuing a prescription to patients on this medication, found that all seven patients identified had been monitored in accordance with national guidance.</p> <p>We reviewed 5 patient records coded as the patient having learning disabilities to ascertain whether these patients had received a recent review and that a care plan was in place. We found that all 5 patients had received a face-to-face review in the last 18 months and care plans were in place. However, two patients' records did not contain detailed information relating to what checks and/or examinations had taken place at their latest face-to-face review.</p>	

Since the August 2022 inspection, the GPs have worked on minimising the coding errors that we identified at that inspection. The incoming GP partner was able to discuss with the inspection team what processes had been put in place to ensure that patient records were being coded correctly and how the use of clinical templates has helped in the review of existing patient registers.

Effective care for the practice population

Findings

- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had introduced a new baby discharge safety-netting process to ensure that the practice contacted new mothers to encourage and remind them to book their 2-week appointment for a mother and baby check.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Not all patient records we viewed relating to the prescribing of inhalers for treatment of asthma showed evidence of the patient having received a follow-up appointment, an asthma medicines review or had their patient record coded correctly. (1)
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

1. Our clinical records review identified seven patients that with had been prescribed more than 12 asthma inhalers during the last 12 months. From this figure we reviewed five patient records and identified four patients who were not always reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm.

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)	24	31	77.4%	Below 80% uptake
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)	37	45	82.2%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	36	45	80.0%	Below 90% minimum
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)	36	45	80.0%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	17	34	50.0%	Below 80% uptake

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

Any additional evidence or comments

The practice had a recall system in place to contact parents to ask them to bring their children to the practice when their vaccinations were due. The practice nurse discussed with us this process and told us they were happy to speak with parents to the process and answer any concerns parents had.

Unverified data provided to us by the practice available for this inspection showed improved performance however, the practice had managed to achieve only one of the five national targets. The achieved target was

having over 80% of children aged 1 and below completing their first course of vaccinations. The most improved vaccination target using the unverified data provided by the practice showed a 20% increase for children aged 5 who received a vaccination for measles, mumps and rubella (two doses of MMR). The remaining indicators showed an uptake in vaccine immunisations at the practice since our August 2022 inspection, but practice was still between 6% and 15% below the World Health Organisation's (WHO) target of between 80% and 90%.

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)	46.9%	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)	53.8%	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)	56.3%	N/A	80.0%	Below 70% uptake
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)	57.1%	53.0%	54.9%	No statistical variation

Any additional evidence or comments

Unverified data provided to the inspection team by the practice showed that 66% of women between the ages of 25-65 and 81% of women aged between 50 & 64 eligible for cervical screening at the practice had been screened between beginning of June 2021 up to mid-June 2023.

As with childhood immunisations, the practice had a recall system in place for women who did not attend the practice for cervical screening. The practice nurse told us that they were happy to speak to women who had concerns about the procedure to reassure them and to explain the importance of the screening. There was a system in place for the practice to follow up on inadequate and abnormal screening results.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y

The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>At our last inspection held on 2 and 8 August 2022, we identified that the provider did not regularly engage in quality improvement activity, based on the limited evidence shown to the inspection team at that time. We saw no evidence of benchmarking activity with (and against) the other providers within the primary care network (PCN) that the provider belonged to.</p> <p>At this inspection, the provider was able to provide the inspection team with evidence of quality improvement activity that had taken place since last inspection. The practice provided the inspection team with a range of quality improvement activities that they had undertaken. These activities looked at both administrative and clinical processes.</p> <p>We viewed a quality improvement activity where the practice looked at patients who were being prescribed medication helping to alleviate sleep problems/conditions, with a view to ensuring that patients were receiving timely clinical reviews for GPs to make an informed decision regarding the continuation of prescribing this type of medication. The practice had identified 41 patients (who fit the criteria) who were contacted by the practice to discuss their usage of the prescribed medication. Following contact and discussions with the identified patients, the practice reduced the number of patients on this type of medication by approximately 18% to 34 patients.</p> <p>We also viewed an audit of a recently recruited member of staff first two patient clinics. A sample of seven patient records were used as the audit, which was undertaken to assure the GPs of the competency of the new staff member. The audit outcomes showed the new member of staff had completed electronic patient records to a good standard, inputting consent gained, noting when a chaperone had been offered and ensuring that the patient record was coded correctly. We also noted that the audit did not specify whether the audit was undertaken over one or several days, whether the auditor was a clinical member of staff, did not identify the criteria used to determine the sample cases and details of what checks were conducted by the auditor to assure themselves that the new member of staff was providing care in accordance with local and national guidelines.</p>	

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>Explanation of any answers and additional evidence:</p> <p>We viewed three staff files and found that on this inspection they contained relevant information to indicate the skills, knowledge and experience to deliver effective care, support and treatment of individual staff members. The practice had a mix of paper copies and online records for staff. Training certificates were kept online, and the practice manager had oversight of training completed by staff.</p> <p>The GPs were able to discuss with the inspection team how they assured themselves of the competence of staff working at the practice. This was confirmed by evidence we viewed on the day of the site visit to the practice as well as in our discussion with the practice nurse.</p> <p>The practice had a programme of learning and development which was centred around the recommended mandatory training for staff in healthcare settings.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection held on the 2 and 8 of August 2022, we identified that the provider did not always ensure that care was delivered and reviewed in a coordinated way when patients were being referred to organisations outside of the practice. At this time this was evidenced by the lack of shared care agreements in place when a patient was receiving care both at the practice and within secondary care. We also saw evidence that the provider was not informing the relevant authority when a diabetic patient was not in compliance with their treatment leading to potential diabetic retinopathy.</p> <p>At our remote clinical records review held on 21 June 2023, we conducted the same search as above and identified 19 patients who had a blood sugar reading of 74mmols who had been diagnosed with diabetic retinopathy. We looked in depth at four patient records and identified the provider was providing care and treatment in line with national guidelines for three patients. The fourth patient was being monitored by the provider but was not engaging with the practice when requested to attend the practice for a review. The provider told us that they had put in place measures to reduce the amount of medication being prescribed by repeat prescription to the patient, so that the patient would have to contact the practice, at which point a review with a clinician would be scheduled.</p> <p>The practice nurse was able to discuss with the inspection team the process of referring patients to services outside of the practice, explaining to us the use of online referral forms and the importance of updating patient</p>	

records to show referrals had been made. We viewed two patient records where we could see the process of referrals to services outside of the practice.

The GPs attended quarterly meetings with local palliative care and health visitor teams. The GPs also worked alongside the other local GP practices within their primary care network (PCN) to have a coordinated approach to the delivery of care within the network.

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

Any additional evidence or comments

At our last focused inspection on the 2 and 8 August 2022, we found that the practice did not always adequately support patients at risk of developing a long-term condition. At the August 2022 inspection, we viewed five patient records where we identified the patient record as not being coded as with pre-diabetes. At the remote clinical records review held on the 21 June 2023, we found that the provider had resolved the previously identified issues in relation to correct coding of pre-diabetes on relevant patient records.

We reviewed the palliative care register and found that the practice identified and provided timely additional support to patients on this register.

Consent to care and treatment

The practice obtained consent to care and treatment but was unable to demonstrate that it always 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

Well-led

Rating: Good

At our last focused inspection held on the 2 and 8 August 2022, we identified the provider was not providing well-led services as there was no evidence of actions taken to address current challenges within the practice and no documented strategy to address future challenges. At this time overall governance at the practice was ineffective with limited policies and procedures in place to assist in the day-to-day running of the practice, there was no evidence of being able to deliver sustainable care and minimal arrangements for identifying, managing and mitigating current and potential risks. Finally, there was little evidence of the use of data for improvement and of learning and improvement within the practice.

We issued the provider with Warning Notices to ensure compliance with Regulation 12 and 17 of the Health and Social Care Act (HSCA)2008 (Regulated Activities) Regulation 2014 following the August 2022 inspection and placed the practice in special measures.

A follow-up inspection held on 18 and 25 January 2023 was undertaken to confirm that the provider had complied with the Warning Notices in relation to Regulation 12 and 17 (Regulated Activities) Regulation 2014 of the HCSA issued following the August 2022 inspection.

At this inspection held on the 21 and 26 of June 2023, the providers were able to demonstrate a clear vision and strategy for the practice, systems had been established to support good management and governance, effective processes for managing risks, issues and performance were in place and relationships between staff members had improved.

As a result of the findings of this inspection, the practice is now rated good for the key question of well-led effective services.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: At the time of our August 2022, the provider of this service was a single-handed GP and was able to talk with the inspection team about future recruitment plans including that of a practice nurse and the difficulty of recruiting staff in general. The inspection team at this time were concerned regarding the provider's limited awareness of how current challenges could impact patient perception of accessing services at the practice, with particularly with reference to limited staff on telephone lines during busier periods. At this inspection, the provider of this service had commenced the process of adding a new partner to the service. The incoming new GP partner officially started work with the then sole provider towards the end of 2022 following the publication of the August 2022 inspection report.	

We conducted an warning notice inspection in January 2023, to ensure that the provider was in compliance with the warning notices issued to them following the August 2022 inspection, and found that the incoming new GP partner had commenced in making improvements to the provision of patient care by reviewing clinical records of patients who had not had not received timely reviews to ensure that medicines prescribed were still relevant for their clinical needs. At this inspection, we found noticeable improvements in the provision and delivery of care, as the provider was reviewing practice registers as a basis to ensure that patients who required regular monitoring was receiving this at regularly intervals.

Staff at the practice told us that both GPs were approachable and that there was a drive within the practice management team to be open and honest, to learn from mistakes and to provide the best provision of care they could not only for patients but also for staff.

Discussions held with the GPs revealed that there were practice development and succession plans in place in place. These plans continued to build on having systems and processes in place to manage the transition of the existing provider’s plans (discussed at the August 2022 inspection) to gradually step back from the running of the practice.

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	P
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
<p>Explanation of any answers and additional evidence:</p> <p>The new incoming partner to the practice afforded staff at the practice the opportunity to review the vision and values of the practice. A revised vision and values statement had been devised and agreed amongst practice staff. The statement put patients at the centre of the work of the practice. Staff we spoke with could talk with us about the revised vision and values of the practice to achieve the best outcomes for patients. We did not see evidence the vision and values had been devised in collaboration with patients or external stakeholders.</p> <p>There was a clear strategy (and commitment) from the management team to continue to improve the provision of care delivered. An example of this strategy was the recruitment of a directly employed clinical pharmacist to undertake medication reviews, working alongside the designated once weekly primary care network clinical pharmacist to ensure timely reviews were occurring for the patients.</p>	

Culture

The practice had a culture which drove quality sustainable care.

	Y/N/Partial
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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
<p>Explanation of any answers and additional evidence:</p> <p>At our August 2022 inspection we noted that not all staff files we viewed showed that equality and diversity training had been completed by staff. At this inspection held on 21 and 26 June 2023, the provider was able to evidence that all staff had undertaken this training.</p> <p>Staff at the practice now had access to a Freedom to Speak Up Guardian. We identified this role was vacant at our August 2022 inspection.</p>	

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

Source	Feedback
Staff interviews	Staff we spoke with were clear on their roles and responsibilities. Staff told us they worked well together and that there was a renewed emphasis on providing quality care. There was an open and honest culture with no blame, which promoted learning when things went well and when they did not go so well. Nursing staff told us they enjoyed their work and they said they were trained effectively and supported to develop strategies to improve patient care and treatment.

Governance arrangements

There were responsibilities, roles and systems of accountability to support 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
Explanation of any answers and additional evidence:	

At our August 2022 inspection, we identified that the governance arrangements at the practice were not regularly reviewed by the provider. There were limited governance structures by way of policies and procedures in place to assist with the day to day running of the practice and governance arrangements with third parties needed reviewing and recording appropriately in some instances.

At this inspection, the management team were able to evidence that the issues relating to governance had been resolved. The practice had employed a Business Manager to work alongside the practice and deputy practice manager and the GPs to devise a comprehensive set of policies and procedures to underpin the governance of the practice. The practice had an in-depth business continuity plan in place in the event of a significant disruption to the delivery of services at the practice.

The practice had safety-netting systems in place to monitor and act upon delays of treatment for patients.

All staff we spoke with were clear about their roles and responsibilities, and who to contact if they were unsure of action to take concerning delivery of care.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our August 2022 inspection, the inspection team were concerned the provider had limited evidence to show relating to processes in place ensuring effective management of the performance of the practice and of staff. We found no monitoring of the locum practice nurse and the phlebotomist and we identified the phlebotomist was working outside the role they were employed for. In addition, we could not identify any arrangements in place to identify, manage and mitigate risk at the practice.</p> <p>At this inspection, the GP management team were able to evidence that the issues relating to the management of risk, performance of the business and of staff had been resolved. Alongside the recruitment of a GP partner, the practice now had access to a business manager who had reviewed existing and formulated new governance systems (along with the GPs and practice manager) to ensure that these were effective to assist in the provision of services at the practice. Staff were able to discuss with the inspection team how having a new incidents and complaints process allowed them a clearer insight into existing and potential future risks to the delivery of services and a basis from which to devised plans to address the identified risks.</p> <p>There was evidence that quality improvement programmes were in place. These programmes covered both clinical and administrative processes. For example, we viewed a quality improvement audit where the practice</p>	

staff monitored the types of requests received to see clinical members of staff, with a view to advising and educating patients that the practice had a range of clinical staff (apart from doctors), who could advise about symptoms.

Existing systems in place to monitor practice performance against local and national targets had been embedded and there were now systems in place to monitor the performance of staff at all levels.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: There was evidence that staff used data to improve performance. The incoming GP partner had devised a programme of regular review of clinical data to assist in achieving the best outcomes for patients.	

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>Explanation of any answers and additional evidence:</p> <p>Since our last inspection, the practice had ensured a range of staff meetings were undertaken at regular intervals. We viewed separate clinical and administrative staff meeting minutes, and noted significant events, incidents and complaints and the learning from these events (and any proposed changes to practice policy as a result) was discussed at each meeting.</p> <p>We viewed two sets of patient participation group (PPG) meeting minutes. These meetings were held every quarter and were attended by members of the PPG along with members of the practice management team and a GP. There was a set agenda, which was distributed to attendees prior to the next meeting. Follow-up actions from the previous meeting was discussed at the beginning of the meeting.</p> <p>The GP management team had improved their interaction and collaborative partnership working with the PCN, the local Integrated Care Board (ICB) and other community health and social care teams.</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.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was evidence that the practice had routinely engaged in continuous learning and that learning was shared effectively within the team.</p> <p>The practice management team told us required annual staff training was provided through using an approved online training academy and they had oversight of training completed by staff.</p> <p>There was now a commitment from all staff to accurately record, learn and improve processes within the practice. The practice recorded any patient safety events not only internally for discussion at team meetings but on the national learning from patient safety events database.</p> <p>The practice had recently introduced a newborn discharge tracker for mothers with newborn babies. The tracker allowed the practice to contact the new mother offering congratulations and asking them to contact the practice at a convenient time so that the practice can book both mother and baby for their 8-week check. The details of the mother along with date contact made, are kept on the tracker and followed up by the practice if no contact has been made by the mother within a specific timeframe.</p>	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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