

## Inspection Evidence Table

The Roxton Practice

(1-542942591)

### Inspection Date:

Date of data download: 14/11/2023

## Overall rating: Good

### Context

The Roxton Practice is situated within the Humber and North Yorkshire Integrated Care Board (ICB) and delivers a General Medical Services (GMS) to a patient population of about 34,000. The practice operates from 3 sites, Immingham, Weelsby View and Keelby. They run dispensary services from Immingham and Keelby. The practice scores 3 on the deprivation measurement scale; the deprivation scale goes from 1 to 10, with 1 being the most deprived. People living in the more deprived areas tend to have greater need for health services.

### Safe

### Rating: Requires Improvement

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y

There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had regular meetings and safeguarding was always a set agenda.</li> <li>The practice was able to share examples of safeguarding cases and described to us the process of raising a safeguarding concern and what steps would be taken. All staff that we spoke to were able to identify who the safeguarding leads were.</li> <li>The practice had strong robust systems in place with community and multi-disciplinary teams to ensure the safety of patients and safeguard them from abuse.</li> </ul>	

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> <ul style="list-style-type: none"> <li>We reviewed 4 recruitment files and found that appropriate recruitment checks had been carried out.</li> </ul>	

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: September 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: September 2023	Y
Actions from fire risk assessment were identified and completed.	Y

### 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: September 23	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>As part of the latest infection prevention and control (IPC) audit carried out the practice had identified that their site at Keelby required upkeep to ensure that IPC standards were met. The practice provided</li> </ul>	

evidence that they had escalated this to NHS property services as soon as the issue had been identified.

### Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We found that the practice had been able to recruit to and expand its clinical staff. As a result of this, staff were offered flexible working arrangements to prevent them from working excessive hours.</li> </ul>	

### Information to deliver safe care and treatment

**Staff had the information they needed to deliver safe care and treatment however greater assurances were required to strengthen systems in place.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	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.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>As part of searches we completed on the practices clinical system we looked at how many documents were waiting to be actioned. Due to the size of the practice, they received a high number of documents everyday which required actioning. However, we found some documents dating back to November 2022 that hadn't been dealt with. Following the inspection that practice provided evidence of a new</li> </ul>	

standard operating procedure for dealing with outstanding tasks and documents. The tasks and documents identified through the inspection had also been reviewed. We received assurances at our site visit that when reviewing old documents no patients had experienced harm or delays in treatment.

- The practice had meetings with the local NHS Trust to look at other solutions to help their document management, this included looking at using Artificial Intelligence (AI) to assist with the volume of documents.
- The practice had also had meetings with another large provider in a neighbouring ICB with a similar patient list size to share good practice and look at ways to improve document management.

### Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	1.07	0.97	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). (01/07/2022 to 30/06/2023) (NHSBSA)	7.3%	8.0%	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 (01/01/2023 to 30/06/2023) (NHSBSA)	6.00	5.45	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	156.9‰	166.2‰	129.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.43	0.47	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	8.6‰	7.2‰	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.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
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.	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> <ul style="list-style-type: none"> <li>• Searches we completed on the practices clinical system identified potentially 387 patients out of 4248 on an ACE inhibitor (medicine to treat blood pressure) or Angiotensin II (medicine to treat blood pressure) who had not received the required monitoring. We looked at 5 patient records and identified 3 patients that had not received monitoring. After the inspection the practice provided an action plan showing how these patients would be monitored by their long-term conditions team in their "one stop clinic" where monitoring of these patients would take place.</li> <li>• We identified 4 patients out of 10 prescribed Leflunomide (a disease modifying anti-rheumatic drug known as a DMARD) who had not received the required monitoring. Following the inspection the practice changed how they monitored and reviewed these patients, this included gradually reducing prescriptions for these patients if they did not comply with the monitoring required. They also improved local systems with care homes to ensure patients received the required monitoring.</li> <li>• As part of searches, we completed on the practices clinical system, we identified 299 patients prescribed gabapentinoids (medicine used to help manage nerve pain) who had not had a review in the last 12 months. We looked in detail at 5 patient records and identified 3 patients that had not received the required monitoring. After the inspection the practice provided assurances for how patients on this medicine would be reviewed. This included providing information on their self-care portal for patients to</li> </ul>	

access. The medicine management team had started contacting patients and using slots in the extended access scheme to assess and review patients.

- We found a comprehensive range of emergency medicines were available. The practice also had a system in place to monitor stock levels of emergency medicines and expiry dates.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> <li>• The practice had a named GP who provided leadership for the dispensary. The dispensing staff could contact GPs if support was needed.</li> <li>• Medicines stock was managed effectively. Stock was ordered as when necessary so there was not an oversupply of medication.</li> <li>• All members of the dispensing team had access to report incidents and record near misses.</li> </ul>	

### 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:	185
Number of events that required action:	185
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice kept a record of all significant events and there was a system in place to review these regularly.</li> <li>Significant events were a standing agenda at all levels of practice meetings, and we saw evidence of learning being achieved and shared across the practice.</li> <li>When we spoke with staff, they told us they were confident in raising significant events and could inform us of the process that would be undertaken.</li> <li>The practice supplied us with evidence to show it was the top reporter of events and near misses in the local area.</li> </ul>	

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

Event	Specific action taken
Abnormal liver function test results, a follow up appointment was not arranged.	The event was discussed at clinical meeting. Tests which require a follow up appointment now result in a task being sent to the care coordinators to book appointments for patients.
Wrong patient selected on online appointment system	The practice discussed this with the provider of the online appointment system. A new process was enabled which automatically copies information to the correct patient record. Since this was implemented, this event has not happened again.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Although there was a system in place for recording and acting on safety alerts, we found that not all patients had received the required monitoring following a safety alert. Our clinical searches found that 21 patients out of 99 on mirabegron had not received an annual blood pressure check. Mirabegron is medicine used to treat an overactive bladder. Following a medicines and healthcare products regulatory agency alert (MHRA) patients are required to have their blood pressure taken annually. We looked at 5 patient records, 3 of these 5 patients were overdue their annual blood pressure monitoring. Following the inspection that practice provided assurances that all patients on this medicine had received the required monitoring.</li> </ul>	

# Effective

# Rating: Good

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

## Effective needs assessment, care and treatment

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

	Y/N/Partial	
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y	
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y	
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y	
We saw no evidence of discrimination when staff made care and treatment decisions.	Y	
Patients' treatment was regularly reviewed and updated.	Partial	
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y	
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y	
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y	
The practice prioritised care for their most clinically vulnerable patients.	Y	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>As part of searches we completed on the practices clinical system we identified 473 patients (1.4% of the practice population) with potentially a missed diagnosis of chronic kidney disease (CKD) 3 – 5. We looked in detail at 5 patients records and identified 4 patients who had a missed diagnosis of CKD 3. Following the inspection, the practice provided assurances for identifying patients with CKD, this included their updated CKD register with 1959 patients (5.7% of the practice population). They provided a thorough action plan detailing how all patients would be coded and their risks assessed. The practice also nominated a lead GP for CKD patients, the lead GP was planning on running a training event for administration staff to improve their knowledge. The practice was also planning an "in person" CKD patient education event to provide more information for patients with local specialist organisations invited, alongside social prescribers, health trainers and dietitians for patients to access specialised support.</li></ul>		



## 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 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.
- We found that the practice had recently started running an acute respiratory infection (ARI) clinic at the Weelsby View Health Centre. Patients who attended who have a diagnosis of asthma were booked for follow up appointments within 72 hours. The practice had been proactively contacting patients who had been seen in accident and emergency and out of hour services with an acute exacerbation of asthma for a review at the ARI clinic.
- 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.
- Our clinical searches identified 92 patients out of 1344 with hypothyroidism who had potentially not received the required monitoring. We looked at 5 patient records and found that when patients were overdue monitoring, they are given an emergency 2-week prescription and informed that medicine will be stopped unless they comply with the monitoring required and have the necessary blood test. Patients can attend the Immingham site to have blood tests Monday – Friday 9am – 12pm without making an appointment. Patients can attend the Weelsby View Health Centre site Monday – Wednesday 9am – 12pm without an appointment.

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 influenzae 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)	300	312	96.2%	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)	363	388	93.6%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	365	388	94.1%	Met 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)	367	388	94.6%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	374	384	97.4%	Met 95% WHO based target

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

Any additional evidence or comments
<ul style="list-style-type: none"> <li>We found that the practice had undertaken analysis of its patient population to understand the uptake of childhood immunisations.</li> <li>To improve uptake they were offering more appointments and were using appointments through their extended access scheme on evenings and weekends to offer more flexibility for patients making appointments.</li> </ul>

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)	66.3%	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)	68.5%	N/A	70.3%	N/A
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)	53.6%	50.2%	54.9%	No statistical variation
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). (6/30/2023 to 6/30/2023) (UKHSA)	69.5%	N/A	80.0%	Below 70% uptake

### Any additional evidence or comments

- We found that the practice had undertaken analysis of its patient population to understand the uptake of cervical cancer screening. The practice identified that a group of their patients from Eastern Europe were unwilling to have the screening. To improve this, the practice had started working with influencers using social media platforms that engaged with hard-to-reach communities.
- To improve uptake they were offering more appointments and were using appointments through their extended access scheme on evenings and weekends outside of normal working hours to offer more flexibility for patients making appointments.
- The practice ran a report every week to see what patients were due to be screened and then contacted them to make appointments.

### Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: <ul style="list-style-type: none"> <li>• The practice had undertaken a significant piece of work providing an online portal to enable patients with long term conditions such as asthma, COPD and hypertension to manage their own conditions more effectively. Through this portal patient's digital literacy was assessed and if patients were able to and it was appropriate for them then their long-term conditions review could be completed online. If this was not appropriate, then patients were offered a face-to-face appointment.</li> <li>• The practice had established the "Connected Health Network" model which allows GPs and specialists for rheumatology from the local NHS Trust working in partnership to manage patient's care within a primary care setting. Instead of referring into the hospital, GPs accessed the Connected Health Network. This ensured that the specialist had direct access to the patient's care record. The consultation was recorded directly onto the patient's record which ensured real time data entry and</li> </ul>	

prevented duplication. From this we saw that the rate of referral into secondary care by GP's was 60% lower than neighbouring Primary Care Networks (PCN). We found that the practice had also used the "Connected Health Network" to reduce the wait time for cardiology referrals, they were reduced from 18 months to 1 week.

- The practice had also completed two cycle audits on:  
Cancer diagnoses  
Oral Iron Preparation  
Hypertension management  
PPI deprescribing  
Long term condition read coding

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had a structured induction system for all members of staff. Staff worked through this induction with support from managers and colleagues until they were deemed competent.</li> <li>• Feedback from CQC staff questionnaires highlighted staff had access to regular appraisals.</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

### Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice promoted the use of their self-care portal where patients could access more information on specific conditions including frequently asked questions. Practical self-care tips were available to encourage patients to monitor and maintain their own health.</li></ul>	

### Consent to care and treatment

**The practice always obtained to demonstrate that it 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

**Responsive**

**Rating: Good**

## Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 am – 18:30 pm (18:30 pm – 20:00 pm extended access)
Tuesday	08:00 am – 18:30 pm (18:30 pm – 20:00 pm extended access)
Wednesday	08:00 am – 18:30 pm (18:30 pm – 20:00 pm extended access)
Thursday	08:00 am – 18:30 pm (18:30 pm – 20:00 pm extended access)
Friday	08:00 am – 18:30 pm (18:30 pm – 20:00 pm extended access)
Appointments available:	
Monday	08:00 am – 19:30 pm
Tuesday	08:00 am – 19:30 pm
Wednesday	08:00 am – 19:30 pm
Thursday	08:00 am – 19:30 pm
Friday	08:00 am – 19:30 pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>• Patients had a named GP who supported them in whatever setting they lived.</li> <li>• The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.</li> <li>• There was a medicines delivery service for housebound patients.</li> </ul>

- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. This included multi-disciplinary teams (MDT) that worked in both primary and community care settings. We saw evidence that as a result of this MDT the practice achieved the lowest attendances per 1,000 patients at accident and emergency for patients over the age of 80. Due to the strong relationships and MDT in community services the practice also had the lowest levels of inpatient stays across their Integrated Care Board (ICB).
- Additional nurse appointments were available until 7pm for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Appointments were available on Saturdays between 9 am and 5pm through the extended access scheme.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice provided us unverified data from the Local Medical Committee (LMC) to show that the practice was offering more appointments per 1,000 of population than neighbouring practices. We saw that the practice offered 37 appointments per 1,000 of the population compared to local averages that were between 19-30 in neighbouring ICBs.

**Access to the service**

**People were able to access care and treatment in a timely way however this could be improved with more flexibility for patients.**

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had several different ways to make an appointment. This included telephoning the practice and making a request through the Ask My GP online portal.</li> <li>• The practice acknowledged that it wanted to improve access via telephone. They had recently procured a new cloud-based system which would offer a callback facility for patients who didn't want to wait. It also linked to the practices clinical system and patients who were coded as clinically vulnerable would jump to the front of the queue.</li> <li>• We found that the practice was primarily run as an "on the day service". This meant that when patients contacted the practice, they were offered appointments the same day. We found that patients were not able to make pre-bookable appointment if the on the day appointment was not convenient for them.</li> </ul>	

The practice acknowledged this and showed how they were starting to bring in pre-bookable appointments for different conditions. In the future they hoped to achieve an 80:20 split between on the day appointments and pre-bookable.

- The practice was able to offer a walk-in service for patients to have blood tests done Monday – Friday 9 – 12 at the Immingham site and Monday – Wednesday 9 – 12 at the Weelsby View site.
- The practice had surveyed over 12,000 patients to assess their digital literacy. Patients that were scored as “advanced tech” or “high tech” patients were encouraged to use the online portal so that appointments were protected for those scored as “no tech” or “low tech”. The practice also provided appointments with “digital champions” who were members of the administration team. They provided teaching and educating for patients who wanted to learn how to use the online portal as well as things like the NHS App.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	40.6%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	56.1%	60.1%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	47.3%	58.0%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	78.1%	79.8%	72.0%	No statistical variation

### Any additional evidence or comments

- The practice monitored access to the practice closely. They identified that telephone access to the practice could be improved, they had recently procured a new cloud-based telephone system to improve the process.
- The practice was primarily run as an on the day service, however the practice acknowledged that this could be difficult for patients if they were not able to attend the same day. They had started introducing some pre-bookable appointments for certain conditions with the plan to make an 80:20 split of on the day and pre-bookable appointments.
- The practice had completed their own survey via the friends and family test and through their Ask My GP online portal. Feedback from the friends and family test showed that the practice had achieved an 80% positive score.



- The practice continually gathered feedback from patients using their online system. Following patient feedback, the time period for patients to request a sick note for work were increased. Increased availability was also provided for patients to request prescriptions.
- Following the inspection, the practice carried out its own survey to assess patients access to services. The practice provided unverified data, they contacted 160 patients who had received an appointment (13.7% of the total appointments available). Over 80% of patients said contacting the practice was either very easy or easy. Over 80% of patients were satisfied with their appointment time and over 80% got the type of appointment they wanted.

Source	Feedback
Give feedback on care submissions to Care Quality Commission	We received 4 submissions on give feedback on care. All 4 were positive, there was praise for staff members attitudes, the availability of appointments and how quickly patients were seen after making a request online.

### 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.	93
Number of complaints we examined.	12
Number of complaints we examined that were satisfactorily handled in a timely way.	12
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

Example(s) of learning from complaints.

Complaint	Specific action taken
Staff member attitude	A holding letter was sent as soon as possible to the complainant, acknowledging that a complaint had been made, providing them with a timescale for an investigation and signposting them to appropriate agencies. Following an investigation, the patient was apologised to, additional training was provided for staff. The patient was also made aware of what to do if they felt their complaint had not been dealt with appropriately.

## Well-led

Rating: Good

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Leaders at the practice identified challenges and put in actions to mitigate these. This included gathering patient feedback from their online appointment system and making changes accordingly. They had also created the connected health network which allowed hospital specialists to access patients care records. This resulted in a reduction of 60% of rheumatology referrals to secondary care compared to local PCNs.</li><li>• Staff feedback received from questionnaires was overwhelmingly positive about how visible and approachable leaders were.</li><li>• The organisation had arrangements in place for succession planning.</li><li>• The practice had systems in place to allow staff to develop into new roles. Staff shared with us examples of how the practice encouraged them to undertake training and personal development. We saw how the lead nurse had started working at the practice as a health care assistant and had then progressed to become a nurse before eventually becoming the lead nurse at the practice.</li></ul>	

### 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
Explanation of any answers and additional evidence:	

- We found that the practice had held a staff feedback session which was used to update the practice’s mission, vision, and values. With staff collaboration they produced a pledge to their patients which they would be accountable to.

**Culture**

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Although the practice had a Freedom to Speak Up Guardian, we found that not all staff were aware of this. We fed this back to the practice and when we undertook our site visit, we saw the practice was promoting the Freedom to Speak Up Guardian</li> <li>• Staff feedback received highlighted that staff felt comfortable to raise concerns.</li> <li>• Staff members also had access to Occupational Health services when required.</li> <li>• It was evident when speaking to staff they felt well supported by the leadership team and would be happy to go to them if they required more support.</li> </ul>	

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

Source	Feedback
Staff feedback received	Staff told us that if they needed to raise any concerns to the management team, they felt confident to do this and that their concerns would be addressed.

**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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice held regular staff meetings for both clinical and non-clinical members of staff. Meetings were minuted and followed an agenda which consisted of any safeguarding concerns, complaints and significant events.</li> </ul>	

### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had a risk register in place which was reviewed regularly and updated appropriately.</li> </ul>	

### 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

### 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 staff and external partners to sustain high quality and sustainable care, however they needed to improve their work with their patient participation group.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>As part of our inspection, we spoke with members of the Patient Participation Group (PPG), although they had regular meetings with the practice, they did not feel valued by them. We fed this back to the practice, after the inspection the practice provided evidence of engaging with their PPG.</li> </ul>	

### Feedback from Patient Participation Group.

Feedback
Members of the PPG told us that they had regular meetings with the practice however they do not feel they are involved with up-and-coming events at the practice and that they are not asked for their comments on these. Although they had good working relationship with the managing director, they don't have any GPs or clinical staff attend meetings.

### Continuous improvement and innovation

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

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

### Examples of continuous learning and improvement

The practice employed a community nurse who led a multi-disciplinary team at the local care homes. We saw evidence that as a result of this MDT the practice achieved the lowest attendances per 1,000 patients at accident and emergency for patients over 80. Due to the strong relationships and MDT in community services the practice also had the lowest levels of inpatient stays across their ICB.

We found that the practice was working to become a digitally innovative practice. They had screened over 12,000 patients for their digital literacy and used this information to tailor services to their needs. For example, patients who were assessed as being high tech users were encouraged to use the online portal for appointments. As a result of this it safeguarded face to face appointments for low tech users who were not able to access digital services.

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

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

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

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

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

#### **Glossary of terms used in the data.**

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