

Care Quality Commission

Inspection Evidence Table

Dr O Z Qureshi's Surgery (1-1535188851)

Inspection dates: 14 and 18 October 2022

Date of data download: 14 October 2022

Overall rating: Good

Safe

Rating: Requires Improvement

We rated the practice Requires Improvement for providing safe services because:

- Recruitment policies and procedures were not fully implemented for all staff and not all recruitment checks had been completed.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- There were gaps in the appropriate and safe use of medicines.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safeguarded from abuse, however, safety risk assessments and staff recruitment processes required review.

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
<ul style="list-style-type: none">• There were regular discussions between the practice and other health and social care professionals to support and protect adults and children at risk of significant harm.	

Recruitment systems	Y/N/Partial
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Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P (1)
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: (1) A recruitment policy was in place and was last reviewed March 2022. However, this had not been fully implemented. We sampled recruitment records for four members of staff and this included two clinical locum members of staff. There were gaps in recruitment records for three staff, which included references, contracts of employment and confidentiality agreements. Following the inspection, evidence was provided the practice were addressing these issues.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 23 November 2021.	Y
There was a fire procedure. Date of fire risk assessment: Not Known	Y
Actions from fire risk assessment were identified and improvements scheduled.	N (1)
(1) Records to support effective risk management of the building were hard to navigate and not all essential checks had been completed. The provider confirmed the last fire risk assessment was completed in October 2017; however, the report was not available. The health and safety file contained a record indicating the landlord had arranged a fire risk assessment for the building in November 2020. This inspection prompted the completion of the new fire risk assessment which was completed on 7 November 2022. Although the shared facilities were all assessed, not all training and management systems pertaining to the practice were included in this assessment. We found a similar issue with completion of the gas safety check; the certificate was dated December 2019 and the provider was not able to establish a more recent check had been completed. The remainder of the certificates for equipment and installations were up to date.	

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. Date of last infection prevention and control audit: 22 September 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	N/A
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The environment was purpose built. An audit had been completed by the community infection prevention and control team in September 2022 and the practice scored 100%. 	

- The practice had appointed a lead for infection, prevention and control (IPC) who carried out regular IPC and hand hygiene audits. On the day of the inspection we observed the premises to be very clean and tidy. A renewal and redecoration programme was in place.
- The practice had taken several precautionary measures and made several changes to their service to keep patients and staff safe during the COVID-19 pandemic.

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"> • Recent recruitment had been positive to fill vacancies in the reception team and provide additional hours. Clinical and non-clinical staff worked flexibly to cover staff absence. Feedback from staff interviews and questionnaires indicated there had been recent staffing pressures, but all members of staff felt well-supported by colleagues and the management team. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had a system to manage test results and ensured prompt clinical oversight of the these. Our clinical searches showed a significant number of outstanding non-urgent tasks on the patient records system. The provider explained they had been left open for further review. We discussed the use of a more suitable task template which would set up reminders and improve the management of tasks. During the site visit, the provider confirmed they had introduced the new template. 	

Appropriate and safe use of medicines

Systems for the appropriate and safe use of medicines, including medicines optimisation were not always managed consistently.

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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.99	0.96	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	8.1%	8.3%	8.5%	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 (01/01/2022 to 30/06/2022) (NHSBSA)	6.00	5.60	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	170.4‰	161.6‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group	0.42	0.56	0.59	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	6.4‰	7.4‰	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.	P (1)
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 structured 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. ²	P (2)
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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.	P (3)
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

Medicines management	Y/N/Partial
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Explanation of any answers and additional evidence, including from clinical searches.

- (1) Storage of blank prescriptions was secure, but the allocation system did not allow for effective reconciliation and safe tracking. Following the inspection, we received evidence the provider had amended the prescription tracker and protocol to ensure prescriptions were allocated to the prescriber.
- (2) The provider recorded structured medicine reviews; however, they had not always been conducted using the correct codes and addressing all the required monitoring. The template had not been used consistently by all clinical staff. During the inspection, the provider confirmed action had been taken.

During the inspection we completed clinical record searches relating to the management of high-risk medicines. In one search, we reviewed the management of patients on a disease modifying antirheumatic drug (DMARD). This medicine required routine monitoring and blood tests due to the risk of significant side effects. Two patients were prescribed this medicine; 1 patient had not had all aspects of the monitoring required and the other record reviewed had a coding issue. This was reviewed by the provider and action taken.

A second search was completed on potassium sparing diuretic medicines. Thirty eight patients were prescribed these medicines and 18 had not received all the required monitoring. Of the 5 records we checked, monitoring had been completed in secondary care for 2 patients and there were coding issues for the remainder.

The use of Gabapentinoid medicines (an anticonvulsant medicine used to treat epilepsy as well as anxiety and some pain types of pain relief) was required to be monitored to ensure the appropriate dosage was being used and risks explained. At the time of inspection, we identified 10 patients who did not have a record of review in the last 12 months, we looked at 5 individual records and saw 4 patients had not had a recent medicines review. This was reviewed by the provider and action taken.

A further search reviewed patients with a potential missed diagnosis of diabetes. Our search identified eight patients. We reviewed 5 of these patients records and 4 patients were not appropriately coded on their records. One patient had not been informed of their diagnosis and 2 patients required more specific testing. During the inspection the provider confirmed they had addressed this.

- (3) The practice did not hold all the recommended emergency medicines. A risk assessment to determine the medicines held had not been completed. This was provided following the inspection.

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: 4	
Number of events that required action: 4	
<ul style="list-style-type: none"> • Staff knew the process for reporting incidents. • Incidents were discussed at meetings, with any learnings shared with relevant staff. 	

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

Event	Specific action taken
Patient information had been shared with another patient.	Both patients contacted; requested information be deleted and provided apologies. Learning shared with staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	P (1)
Staff understood how to deal with alerts.	Y
<p>(1) The practice had a system to disseminate safety alerts to the appropriate staff for information and or action. We completed clinical record searches of medicines identified in safety alerts and reviewed medicines which have risks for female patients of childbearing age. We found there were 19 patients prescribed these medicines. We reviewed 5 patient records; in 1 record the discussion about the potential risks had not been recorded and two records showed those patients required review of their contraception. During the site visit the provider confirmed they had followed this up.</p>	

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. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	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 prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">All requests for appointments were triaged by clinical staff and systems were in place to escalate any concerns about patients contacting the practice. Urgent appointment requests were reviewed by clinical staff. Systems were in place to manage and monitor urgent referrals.The practice had continued to provide an effective patient focused service during the pandemic.	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

- 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

- During the inspection we completed clinical records searches to review the management of patients with long term conditions. One search reviewed the care of patients to check they had received a thyroid test in the last 18 months and our search found 13 patients out of 321 who had not had this test. We looked at 5 of these patients records. This showed that although they had all received medicine reviews, this test had not been carried out for four patients. During the inspection, the provider confirmed this had been followed up.
- A second search reviewed the recording of patients diagnosed with diabetic retinopathy; a complication of diabetes caused by high blood sugar levels. Our search identified 17 patients whose last blood sugar test showed high sugar levels. We undertook a review of 5 patients' records, which showed all patients had received a medication and diabetic review within the last 12 months.
- Another search looked at patients with asthma who had been prescribed two or more courses of rescue steroids in the last 12 months and the search showed there were 17 patients. We looked at five patient records. All patients were reviewed before steroid medicine was prescribed and one patient was not reviewed after steroid prescribing. All 5 patients had an asthma review in the last 12 months and provided with a care plan.
- A further search looked at patients with chronic kidney disease stages 4 or 5 to check they had had the required monitoring tests. Our search found 6 patients who had not received the required monitoring in the last 18 months. We looked at 5 of these records and found all patients had received monitoring in secondary care. The provider confirmed they would download the information onto the practice record system.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. The searches showed some backlog with completion. The provider confirmed the primary care network (PCN) had recently recruited a new pharmacy team who would support the practice with these.
- 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.

- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	34	37	91.9%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	42	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	42	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	42	100.0%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	43	97.7%	Met 95% WHO based target

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

Any additional evidence or comments

- The practice maintained high levels of uptake with the childhood immunisation programme and had also managed to maintain this in most age groups during the pandemic.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	79.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	14.4%	41.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	70.5%	63.4%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	37.0%	47.5%	55.4%	No statistical variation

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.

Any additional evidence or comments
<ul style="list-style-type: none"> The provider monitored the practice's performance in relation to cervical screening. Saturday morning and evening screening clinics were held to offer more accessible 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
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

The practice undertook a range of clinical audits. We reviewed a selection of completed clinical audits conducted by the practice during 2021 and 2022:

The diagnosis and management of urinary tract infections for patients aged 65 and over (not catheterised) had been reviewed to ensure best practice guidance was being followed in relation to diagnosis, prescribing and management. The data from November and December 2021 was reviewed for 35 patients. Several areas for improvement were identified including following best practice guidance

in relation to recording the patient's symptoms, sending the urine sample for culture and duration of the course. An action plan was put in place to follow the local prescribing guidelines and other management changes.

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 (1)
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.	P (2)
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>(1) Staff considered the provider supportive of their training and development needs.</p> <p>(2) The appraisal programme had been halted during the COVID-19 pandemic. The practice manager had introduced a new approach to the appraisal format and meetings had been scheduled for all staff in November 2022. Additional one-to-one meetings for staff were due to commence over the next months.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<ul style="list-style-type: none"> The practice was part of a primary care network (PCN) of 8 practices. They worked together to provide access to additional services such as a pharmacist, mental health nurse, a first contact physiotherapist, staff training and multi-disciplinary approaches to safeguarding, chronic and complex and palliative care management. 	

- The practice had appointed a link nurse to support patients with a learning disability. They completed annual reviews and worked effectively with the community learning disability team to access additional support with their patients' health and wellbeing.

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
<ul style="list-style-type: none"> • The practice published a good range of information on their website to sign post people for self-help and wellbeing support. This included, links to NHS information, local services, symptom checking, conditions and illnesses and national organisations. • The practice had access to local social prescribing services and a wellbeing coordinator for one of the organisations was to be based in the building to facilitate greater access. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y

Responsive

Rating: inspected but not rated.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<ul style="list-style-type: none">• During the pandemic a telephone triage system was introduced offering the same day triage with call backs available throughout the day and time slots could be requested. Appointments with all healthcare professionals were available on the same day if clinically appropriate.• The practice offered an appointment invitation link option via a secure text message, so patients could book appointments for vaccinations, cervical smears and blood tests etc without having to contact the surgery.• The practice manager confirmed 46% of the practice population now had access to on-line services to check, book, cancel appointments and order repeat prescriptions, which was a significant increase.• The practice used 'Push Doctor' an on-line consultation service working in partnership with the NHS and also referred patients to the community pharmacy where appropriate. This had helped the practice cope with the increase in demand for appointments.	

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
<ul style="list-style-type: none">The senior management team understood the issues, challenges and priorities of the service. They worked collaboratively with their PCN partners to improve access arrangements and extend the range of services available for the patient population.Staff felt supported by the management team and their colleagues. They described an inclusive working environment which supported them to develop in their roles. Succession planning was ongoing.Clear management and staffing structures were in place so staff understood their roles and responsibilities clearly. Staff were allocated lead roles which included areas such as infection, prevention and control, safeguarding and training.	

Vision and strategy

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

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

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y

There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	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
<ul style="list-style-type: none"> Overall, there were high levels of satisfaction across staff we spoke with or received surveys from. Staff were proud of the organisation, felt valued, included and involved in the practice. They were motivated to provide a good service. 	

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

Source	Feedback
CQC staff survey forms.	<ul style="list-style-type: none"> Staff felt the practice was a happy place to work; they felt listened to and part of a strong and supportive team. Staff considered they had good access to training and staff development. Staff felt there were staffing pressures but understood turnover and staff absence had been difficult. They recognised the provider had used temporary staff when available and recruitment to administration roles had been positive in recent weeks.

Governance arrangements

Although there were clear roles and responsibilities, the practice's governance and management systems did not always operate effectively.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P (1)
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	P (2)
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
(P1 and P2) The practice had a governance framework structure, however there was inconsistency in the oversight of some management systems, as we identified several concerns during the inspection that had not been identified or resolved by the practice.	

Managing risks, issues and performance

The practice generally had 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.	P (1)
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
(1) There were areas relating to recruitment, medicines and safety of the premises which had not been managed effectively. Oversight by the leadership team had not been consistent. Following the inspection, evidence was provided that the practice had audited the staff recruitment records and obtained/completed the outstanding checks. They had revised the allocation of blank prescriptions. The practice manager had also collaborated with the lead in the other practice at the medical centre to review and improve the building safety management systems.	

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 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.	N
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
<ul style="list-style-type: none"> The practice Patient Participation Group (PPG) had disbanded prior to the COVID-19 pandemic. There had been a poor response to the advert posted on the practice website inviting people to join the new group and the practice manager was now planning to hold a PPG promotional event to encourage patients to be involved. The practice used the NHS friends and family surveys as feedback. Feedback was assessed and learning implemented where required to improve service quality. 	

Continuous improvement and innovation

There were 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
<ul style="list-style-type: none"> The provider was working towards accreditation in support of the practice becoming a teaching practice for trainee medical staff. 	

- There was collaborative working with the other practices in the PCN to share best practice and learning.
- Significant events, complaints and feedback were used to make improvements and any learning shared with relevant staff at the practice.

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 SICBL 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 SICBL 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.