

# Care Quality Commission

## Inspection Evidence Table

### Beacon Medical (1-540492553)

Inspection date: 14 and 19 July 2022

Date of data download: 12 July 2022

## Overall rating: Good

We inspected the practice on the 14 and 19 July 2022. The practice is rated Good overall and in the effective and well-led key questions.

## Safe

## Rating: Requires Improvement.

When we inspected the practice in July 2022, 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.
- The practice did not have adequate systems for the appropriate and safe use of medicines (vaccines).
- The practice did not have appropriate systems for the safe storage and use of liquid nitrogen.

### Safety systems and processes

**The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.**

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

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P (1) and (2)
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) Checks on recruitment records for five members of staff showed most contained the appropriate checks and records in line with the practice's recruitment policy. The records for two members of clinical staff did not contain their employment history or contract of employment and contained only one written reference. Following the inspection, the practice manager confirmed they had put in place a new recruitment checklist and had planned to complete a full audit of the recruitment records.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessments: 20 January 2022 and 23 March 2022. Minimal actions from the general health and safety risk assessments had been identified and all improvement work completed.  (1) The practice used liquid nitrogen for cryotherapy treatment. The storage of liquid nitrogen was not risk managed appropriately. The building where the liquid nitrogen was stored was secure, however it contained flammable items and temperature monitoring was not completed to ensure the liquid nitrogen was stored below 50 degrees Celsius. The hazard warning sign was not sited on the external aspect of the building. Staff were not provided with appropriate personal protective equipment (PPE) when decanting the liquid nitrogen. Following the inspection, the practice manager confirmed the practice had paused the cryotherapy treatment until more appropriate, safe storage and handling arrangements were in place. A contractor was due to complete a risk assessment to identify a safe site on the premises; suitable PPE and a new hazard warning sign had been obtained.	N (1)
There was a fire procedure.	Y (1) and (2)
Date of fire risk assessment: 8 December 2021 <ul style="list-style-type: none"> <li>The fire risk assessment had identified significant areas of concern, including areas of high risk. Records showed a comprehensive action plan had been developed and implemented. The majority of high and medium risk areas had been completed and the remaining actions had a date set for completion.</li> <li>Additional fire marshall training had been completed and further planned, to ensure sufficient staff were competent in safely implementing the emergency arrangements. A recent staff fire drill had been completed. Weekly checks of the fire alarm system had not always been completed by staff, which the practice manager confirmed they would monitor more closely.</li> </ul>	

## Infection prevention and control

## Appropriate standards of cleanliness and hygiene were met in most areas.

	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: 20 October 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	P (1) (2) (3)
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<p>(1) The practice had achieved a compliance rating of 68% with the infection, prevention and control (IPC) audit in September 2019. Following this, the practice had introduced a new IPC lead and worked closely with the practice staff, the local IPC team and the cleaning contractors to improve standards. The audit results in October 2021 were much improved and the practice compliance rating increased to 98%.</p> <p>(2) There were good standards of cleaning and hygiene in the practice when we visited except for many of the carpets, which were heavily stained. The flooring in one of the treatment rooms was carpeted. The practice told us it was the responsibility of the property's landlord to address the shortfalls with the flooring. The landlord had provided a completion date of the 31 December 2022; however, the practice had identified this work was now a priority and were in the process of negotiating an earlier completion date. Following the inspection, the practice confirmed they were arranging for their own contractors to complete improvement works to the higher risk areas.</p> <p>(3) A Legionella risk assessment had been completed for the building on 28 June 2022 and quotes were currently being obtained for all improvement works.</p>	

## 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>Staff covered each other during busy periods or when staff were absent. They said there was enough staff to provide safe, high quality care. We received six staff feedback forms; one member of staff felt covering staff sickness and absence caused additional pressure. The practice</li> </ul>	

confirmed additional cover had been provided for staff absence and staff teams could work flexibly across areas of the service when needed.

**Information to deliver safe care and treatment**

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had a system in place to ensure all test results and information relating to patients was acted on appropriately and in a timely manner.</li> </ul>	

## Appropriate and safe use of medicines

The practice did not always have systems for the appropriate and safe use of medicines.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.96	0.94	0.79	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	10.0%	8.5%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	6.27	5.63	5.29	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	159.0‰	162.2‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.44	0.59	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.0‰	7.5‰	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

Medicines management	Y/N/Partial
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.	N/A
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.	Y (1)
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	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.	N (2)
<p>Explanation of any answers and additional evidence:</p> <p>(1) As part of the inspection, we undertook a series of remote searches of the practice's clinical records system to review procedures around medicines management and prescribing. We found patients prescribed high risk medicines were generally well-managed and monitoring was completed. Although there were a small number of examples where a review had not taken place within the recommended timeframe. Where patients were receiving specialist secondary care, relevant records had not always been downloaded to the clinical records system. A search identifying patients on particular medicines in combination (a medicine to reduce blood pressure and a medicine to reduce high cholesterol), which had been identified in a medical alert, showed four patients had been prescribed these medicines and following audit, all patients prescriptions had recently been reviewed and changed. Clinical searches showed good management of patients on medicines to treat heart rhythm disorders, heart failure and mood disorder; the patients had all received appropriate monitoring. A search reviewed the prescribing of a high-risk medicine primarily used to treat arthritis. This identified five patients who were prescribed this medicine, with three patients observed not to have received all required monitoring. One record required appropriate coding. The provider said they would review these patients.</p>	

Medicines management	Y/N/Partial
<p>(2) Vaccines and other medicines which required refrigeration were stored securely in lockable fridges. Staff checked the temperature of each fridge twice daily to ensure it had not exceeded recommended temperature ranges. Records showed the temperature of two fridges containing influenza vaccines had exceeded the maximum temperature for consecutive days in September and October 2021. Clear procedures were not in place to guide staff on the action to take if the temperatures of the vaccine fridges were not within the recommended ranges. There were no records to evidence staff had investigated, reported or recorded any action taken in respect of the anomalous temperatures identified during the inspection. Data logger records for these dates were not available. We also found the records of temperatures for a fridge containing immunisations for babies had exceeded the recommended temperatures on the 18 July and 19 July 2022. The vaccination lead confirmed they had not been informed of the temperatures. They checked the data logger records which showed the temperatures were within the recommended range. Following the inspection, the practice completed an investigation and shared their findings with NHS Humber and North Yorkshire Integrated Care Scheme (ICS). There was sufficient assurance that a break in the cold chain had not taken place. Improvement action had been taken which included the implementation of a new policy and procedure, staff training, new recording systems and increased oversight by the vaccine lead and practice manager.</p>	

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

**The practice learned and made improvements when things went wrong.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months: 26	Y
Number of events that required action: 11	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Staff knew the process for reporting incidents.</li> <li>• Incidents were discussed at meetings, with any learnings shared with relevant staff.</li> </ul>	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Patient correspondence for a patient with the same name but different date of birth had been scanned to the incorrect patient record.	The letter and coded entry were removed from the patient's records and learning shared with staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had a system to disseminate safety alerts to the appropriate staff for information/action.</li> <li>• We completed clinical records searches of medicines identified in safety alerts. We reviewed patients prescribed a medicine which may present a risk to women of child bearing age. We found three patients prescribed this type of medicine and reviewed their patient records. All records showed advice had been given relating contraception and the risks of the medicine.</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.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y

### 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 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

- As part of our inspection, we conducted a series of additional searches on patient records to review the practices' procedures for the management of patients with long term conditions. We found patients with long-term conditions were mostly offered a structured annual review to check their health and medicines needs were being met and for patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- One search reviewed the management of patients with asthma who had been prescribed two or more courses of rescue steroids within the last 12 months. We reviewed five patients' records. In all cases the reason for prescribing the rescue medicine and detail of symptoms was recorded and there was evidence of systems to review response to the treatment within a week of an acute exacerbation of asthma. Two patients had not received an annual asthma review within the last 12 months. The provider said they would review this.
- A second search reviewed the monitoring of patients with a thyroid condition who had not had a thyroid function test in the last 18 months. Our search identified nine patients out of 42 had not received an appropriate test within this period and had not attended for a review. We undertook a detailed review of five patients' records, which showed one patient had been invited but not attended and two patients were having the checks in secondary care settings. The provider said they would review this.
- A third search reviewed the recording of patients diagnosed with diabetic retinopathy; a complication of diabetes caused by high blood sugar levels. Our search identified 104 patients had high blood sugar levels at the last blood test. We reviewed five patient records and all, but one had had a review following their blood tests.
- A fourth search reviewed patients who had chronic kidney disease who had not had their bloods monitored in the last nine months. All three patients reviewed had received appropriate monitoring.
- Medication reviews were carried out on patients on repeat medicines. Of the four records we reviewed, three were well documented and one was overdue.
- 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)	94	96	97.9%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	110	112	98.2%	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)	110	112	98.2%	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)	110	112	98.2%	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)	107	111	96.4%	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

The practice had maintained high levels of uptake with the childhood immunisation programme since at least 2018 and they had managed to also maintain this during the pandemic.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	76.4%	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)	3.8%	39.9%	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)	70.2%	62.9%	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)	48.1%	47.8%	55.4%	No statistical variation

#### Any additional evidence or comments

- The provider was aware of the practice's performance in relation to cervical screening and had taken action to make improvements. For example: patients whose first language was not English were sent information in their first language and translation services arranged to provide an explanation of the procedure and answer any queries. Saturday morning screening clinics were held to offer more accessible appointments.
- Unverified data showed uptake rates had improved since December 2021: 81.1% of eligible patients aged 50-64 years and 80.3% of eligible patients aged 25-49 years had received cervical screening.
- We discussed the unusually low data for breast screening with the practice manager. They had contacted the regional breast screening lead who confirmed satisfactory screening statistics for the practice. The practice manager confirmed the preliminary checks indicated a coding irregularity which was being followed up.

#### 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. What system in place?	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

- We reviewed a selection of completed clinical audits conducted by the practice during 2021 and 2022. These included:
- 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 June, July, August and September 2021 was reviewed for 38 patients. Several areas for improvement were identified including following best practice guidance in relation to the type of antibiotic prescribed and duration of the course. An action plan was put in place to follow the local prescribing guidelines and other management changes.
- An audit to check prescribing of particular medicines in combination, which was the subject of a safety alert, had been carried out. The practice was 89.5% compliant. Planned changes included liaison with the pharmacist, placing an alert on the patient records system, completing searches every six months and completing a referral for secondary care for assessment. A further audit was scheduled in six months to ensure the standards were maintained.
- An audit identifying adults prescribed regular strong opioids (in non-cancer pain) was completed to review the appropriateness of the prescribing and whether the dose could be tapered or stopped. Actions included improving the standard of recording and completing regular reviews.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff had regular appraisals where they could discuss their training and development needs. They found the provider supportive of staff training and development for the roles and responsibilities.</li> <li>• The GP's were responsible for all prescribing at the practice.</li> <li>• A formal clinical supervision programme was in place and records audits were undertaken to ensure the competence of staff employed in advance clinical practice roles.</li> </ul>	

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Beacon Medical was the lead practice for their Primary Care Network (PCN) care home project. The practice held a weekly care home multi-disciplinary team meeting (MDT) where concerns about patients, new admissions and patients recently discharged from hospital were discussed.</li> <li>• Palliative care and high-risk patients were discussed at the practice clinical meetings. The practice worked closely with health visitors and school nurses in relation to children's care.</li> </ul>	

- 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>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.</li> <li>The practice worked closely with 'Thrive', the local health and wellbeing social prescribing service and referred patients for additional advice and support. The practice had implemented new mental health wellbeing services and accessed additional support from external services to support patients' mental health needs.</li> <li>The practice was an Armed Forces veteran friendly accredited practice and offered sign posting to support services and extended appointments where necessary.</li> </ul>	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
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## Responsive

**Rating: inspected but not rated.**

### Access to the service

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

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*

	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	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

#### Explanation of any answers and additional evidence:

- The practice had remained open throughout the pandemic providing a range of appointments including face to face appointments, telephone consultations and video calls.
- The provider had invested in a new telephony system which had improved telephone access. The new system enabled the management team to monitor incoming calls, abandoned calls and call waiting times. Staff monitored the call queues and opened up additional lines when needed.
- The practice had an established telephone triage system. In addition, all patients could use the on-line facility, available between 6 am and 10 am, to be added to the same day triage list. Systems were in place to manage and monitor urgent referrals.
- A pre-booking appointment system had been introduced. The practice also offered an appointment invitation link option via a secure text message, so patients could book



appointments for vaccinations, cervical smears, blood pressure checks and blood tests etc without having to contact the surgery.

- The practice maintained a register of asylum seekers, refugees and other migrants and offered support with translation services, extended appointments and information in their own language. All Arabic speaking patients within this cohort for the area were registered with the practice and assigned to an Arabic speaking GP.

## 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>• There were no current issues around GP succession. A new nursing structure had been implemented and recruitment was underway to replace staff who had left due to retirement or redundancy.</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: <ul style="list-style-type: none"> <li>• The practice had an experienced leadership team in place, who understood both the local and national challenges to healthcare and continued to improve and adapt their service to provide effective care to their patients. The practice had recently joined a newly formed primary care network (PCN).</li> </ul>	

- The practice's mission statement was to provide professional, accessible, high quality, comprehensive healthcare services that inspired confidence in their patients and their community. Staff told us they understood their role in meeting this vision and we could see the practice team were motivated and passionate about providing high standards of patient centered care.

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Feedback from all staff ( six surveys) were positive in relation to the management of the practice, support, team work and approachability of the leadership team. Some of the comments praised the practice manager for the support they had provided on both a personal and professional basis during the pandemic.</li> <li>• Leaders at the practice continually supported the wellbeing of staff, with a commitment to supporting team welfare through various wellbeing initiatives. The leadership team had set up running and fitness clubs with positive results. Other initiatives such as group lunches were encouraged, and the practice provided pizza and ice creams for staff on hot days.</li> </ul>	

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

Source	Feedback
Staff questionnaire (CQC)	<ul style="list-style-type: none"> <li>• Staff were aware of the practice's vision and strategy.</li> <li>• They felt leaders in the practice were visible and approachable.</li> <li>• Staff felt supported and there was a positive, inclusive, team ethic.</li> <li>• Some staff felt improvements were needed to the flooring in the building.</li> <li>• Staff were proud of the forward-thinking approach to change and improvements to the service provision.</li> </ul>

## 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.	Y
Explanation of any answers and additional evidence:	
<p>(1) The practice had a governance framework structure, however there was some 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. These included effective monitoring of fridge temperatures, safe storage and handling of liquid nitrogen and shortfalls in the recruitment practices.</p>	

## 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.	P (1)
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 (2)
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:	
<p>(1) There were areas relating to recruitment, vaccine safety and the safe use of liquid nitrogen which had not been effectively managed. Oversight by the leadership team had not been consistent.</p> <p>(2) Arrangements for ensuring risks had been identified, managed and mitigated were not evidenced consistently. The safe use and handling of liquid nitrogen (a substance hazardous to health) had not been appropriately risk managed. Protocols, to direct staff on the action to take when fridge temperatures were recorded outside the recommended range, were confusing. Improvement action was taken during and following the inspection to mitigate further risks.</p>	

**The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic**

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y

**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

### 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"> <li>Staff at the practice were very proud to have been one of the central vaccination sites for North East Lincolnshire CCG; vaccinating over 60,000 patients across multiple PCNs. They had provided the majority of resources to complete this work, whilst continuing to support their patients. In recognition, the practice was awarded an NHS Hidden Heroes Award in 2021 for outstanding service during the pandemic.</li> <li>The practice paused patient participation group (PPG) meetings during the COVID-19 pandemic as many members had left. They were in the process of resurrecting the group and encouraging new members to join to represent the different population groups. The PPG was promoted on the practice website.</li> <li>We received 20 completed questionnaires from patients. Two of the questionnaires detailed delays in accessing the practice via telephone. The remainder of the feedback was very positive in relation to the quality of care; timeliness of staff response and ease of making appointment; friendly, caring and compassionate approach and very helpful and professional staff.</li> </ul>	

### Continuous improvement and innovation

#### There was 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
Explanation of any answers and additional evidence:	

- The practice was a teaching practice and supported medical students on placement from the Hull York Medical School. The practice also supported nursing students on placement from Hull University.
- Significant events and complaints were used to make improvements and any learning shared with relevant staff at the practice.
- The practice had commenced a new project around health inequalities and had identified those patients who had not attended cervical screening who were classified as living in deprived areas or where English was not their first language. They were contacting patients in their first language via text message, offering translation services and providing additional screening clinics on a Saturday morning to provide more accessible appointments. Following analysis of the project, the leadership team planned to move on to bowel screening.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

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