

# Care Quality Commission

## Inspection Evidence Table

### Lockfield Surgery (1-7457906332)

Inspection date: 28 July 2022

Date of data download: 02 August 2022

### Overall rating: Good

The practice was inspected 29 November 2021 and rated Inadequate overall. Following the inspection, we took enforcement actions against the provider and the service was placed in special measures. A focused inspection carried out on 29 March 2022 confirmed the provider had met the legal requirements in relation to the enforcement actions. This was a comprehensive inspection to update the provider's rating and assess if the practice could be removed from special measures.

During this inspection the overall rating is Good. Risks were proactively assessed and managed. There were improvements to the management of patients' care and treatment. Comprehensive assurance systems were in place with effective governance oversight to monitor the quality, safety and effectiveness of the service. Further improvements were required in completing medicine reviews and the uptake of cancer screening and childhood immunisation.

### Safe

### Rating: Requires improvement

We inspected the practice in November 2021 and rated the practice Inadequate for safe services as the practice did not have reliable systems in place for the appropriate and safe use of medicines. Staff did not always have the information they needed to deliver safe care and treatment. There was a lack of a systematic structured approach with effective clinical oversight of patient information.

During this inspection we rated the practice Requires improvement. The practice was proactively assessing and managing risks. There were effective assurance systems with clinical oversight for monitoring actions and improvements. There were structured plans in place to assess all patients due a medicine review prioritising high risk patients, however since November 2021 less than half of those who required a review at that time had received one.

## Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>In order to maintain oversight of the practice safeguarding registers and ensure information was accurate and up to date regular searches were carried out on the clinical system. Information requests were made to the local safeguarding teams for updates. Concerns about adults and children in the same household were cross referenced in the appropriate records.</li> <li>The practice was able to demonstrate a multidisciplinary approach to safeguarding. There were regular formal discussions with health and social care professionals such as the health visitor. The safeguarding lead participated in local safeguarding meetings to share information and discuss concerns.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We looked at two staff files including recently employed staff. There was evidence of checks undertaken as part of the recruitment process such as a full employment history, references and proof of identity in line with the relevant guidance, and policies.</li> <li>The practice was liaising with the local NHS occupational health service to review and update the vaccination status for all staff to ensure compliance with guidelines.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2022 to April 2022 (various)	Y
There was a fire procedure.	Y
Date of fire risk assessment: March 2022 Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• A number of risk assessments had been completed in areas of health and safety such as the use of equipment, premises security and potential hazards. There was a risk assessment tool to identify and control risks.</li> <li>• Risk assessments and data sheets were in place for the storage of hazardous substances which had been reviewed and updated.</li> <li>• Systems were in place for the regular checks of fire alarms, extinguishers and fire evacuation procedures were in place.</li> <li>• There were arrangements in place for the regular testing of electrical appliances which was undertaken in October 2021. The calibration of medical devices was undertaken in December 2021.</li> </ul>	

## 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: February 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• During the last inspection in March 2022 we saw that a comprehensive infection prevention control (IPC) audit had been completed in February 2022, by the local NHS Infection Prevention and Control team. The majority of the recommendations from the audit had been actioned or were in progress. This included replacing all carpeted areas with wipeable flooring, the practice had prioritised replacing the carpet in clinical areas and there were plans to complete a self-assessment audit to monitor infection prevention and control on an ongoing basis.</li> <li>• At this inspection we saw all of the clinical rooms had carpet replaced with new wipeable flooring. There were further plans to replace worn and stained carpet in the entrance and patient waiting areas.</li> </ul>	

- A self-assessment audit had been completed in May 2022 to monitor infection prevention and control procedures on a regular basis. The findings of the audit showed minor areas for improvement such as ensuring cleaning records were completed to evidence cleaning undertaken, all identified areas were actioned and completed by July 2022.

## 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:

- Staff had received training on managing a medical emergency, including identifying signs and symptoms of sepsis.
- Staff had access to equipment and medicines to deal with medical emergencies (including suspected sepsis). This included medical oxygen and a defibrillator which were regularly checked to ensure they were in good working order.

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>A GP specialist advisor to the Care Quality Commission (CQC) accessed the practice's clinical system to carry out searches and review patient records. Evidence reviewed showed :</p> <ul style="list-style-type: none"> <li>• There was oversight of care records and clinical data with an effective system in place to manage workflow including the review of test results, management of correspondence and clinical coding.</li> <li>• Systems were in place to ensure referrals were sent in a timely manner with safety netting to ensure follow up of any delays for example, urgent two week wait referrals where cancer was suspected.</li> <li>• There was a documented approach to the management of a patient's clinical condition including test results for example, patients on high risk medicines had the required monitoring in place.</li> <li>• The practice followed up patients who did not always engage or were not compliant with their treatment. There was clear documentation of actions taken such as alerts added to the patient's records and reducing the duration of the prescription to prompt the patient to attend.</li> <li>• There was clinical oversight of allied health professionals including non-medical prescribers by the process of clinical supervision and audit of prescribing and consultation decisions.</li> </ul>	

## Appropriate and safe use of medicines

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

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)	1.10	0.81	0.79	Tending towards variation (negative)
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)	11.0%	6.2%	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)	4.88	5.21	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	158.1‰	138.1‰	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)	1.03	0.66	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	14.6‰	8.7‰	6.8‰	Variation (negative)

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.	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.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice could demonstrate the prescribing competence of non-medical prescribers, there was regular review of prescribing practice supported by clinical supervision.</li> <li>At the inspection in November 2021, a search of the clinical system showed there were 1686 patients on four or more repeat prescription items issued in the last 12 months who had not received a medicine review. A follow up inspection in March 2022 showed the practice had completed 436 medicine reviews. During this inspection we found the practice had continued to make progress and had formed an action plan to address the backlog and systems and processes were in place to reduce the likelihood of recurrence.</li> <li>A GP specialist advisor to CQC accessed the clinical patient records system to carry out searches of patient records and review clinical consultations. The search showed a further 311</li> </ul>	

medicine reviews were completed since March 2022, the total number of patients with no review was 963 compared to 1686 in November 2021. The practice had a structured plan in place to review all outstanding patients and continued with a targeted approach prioritising high risk patients. The clinical capacity was increased to undertake reviews both opportunistically and during booked appointments. A search on the clinical system was introduced to flag any patients due medicine reviews, this was run automatically every two weeks. Leaders shared some of the challenges with clearing the backlog, this included structured medicine reviews which took much longer to complete as they were comprehensive reviews which we saw evidence of during records we reviewed. Actions taken to sustain improvements included, revised practice protocols, training for staff and regular audits. However, since November 2021 less than half of those who required a review at that time had received one.

- The practice was able to demonstrate improvements in the management of information about patient's medicines including changes made by other services. For patients who were receiving monitoring of their high-risk medicine in secondary care services, the practice had liaised with secondary care services requesting a shared care agreement be put in place or an update to an existing agreement.
- A system was in place to undertake clinical searches every two weeks to monitor high risk medicines according to The National Institute for Health and Care Excellence (NICE) guidelines. This was demonstrated by results of clinical searches and the review of records. For example, there were 1171 patients prescribed a high-risk medicine to help lower blood pressure, of these patients, seven patients did not have up to date monitoring in place. A further review of these seven patient records showed some patients were not responding to requests for monitoring and the practice had taken appropriate action to review the patient as per practice protocol. This included adding markers to the patient's record to flag the risk and reduce the duration of the prescription and prompt the patient to attend for monitoring prior to re-issuing the prescription.
- We saw other examples where patients on high risk medicines had received appropriate monitoring, or arrangements were in place for the patient to attend monitoring. These included patients on medicines to help thin the blood, mood stabilisers and medicines used to treat fluid build up.
- Prescribing data available at the time of the inspection showed the practice was above local and national averages for antimicrobial and psychotropics prescribing. This had not improved since the comprehensive inspection in November 2021; however, the practice had taken action to review prescribing in these areas. An audit on the prescribing of antibiotics in children aged 0-4 years was completed with areas for improvement identified such as the use of delayed prescribing. A review of patients prescribed psychotropics was undertaken, the practice liaised with relevant secondary care services where the prescription was issued to understand if any changes could be made, the review identified the medicine remained appropriate for the patient's needs.
- Systems and processes were implemented to improve medicine management within the practice and ensure changes were embedded and reviewed on an ongoing basis. This included policies and procedures for high-risk medicines and prescribing. A dedicated medicine management team with clear roles and responsibilities led by the advance clinical practitioner (ACP) and quality improvement activities such as audits.



**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:	15
Number of events that required action:	15
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Staff were able to describe the system in place to report incidents and a policy was in place.</li> <li>Staff told us that significant events were discussed in clinical meetings, minutes of meetings we reviewed demonstrated this.</li> </ul>	

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

Event	Specific action taken
Patient treated for health condition but not referred to specialist for further management.	Patient referred to specialist, reinforced best practice guidelines and need to refer all patients accordingly.
Patients request for urgent repeat prescription not issued due to concerns of excessive use.	Record and prescription were reviewed before patient ran out of medicine; training needs identified policy updated to address urgent request for high risk patients.

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Patient safety alerts were discussed in clinical meetings, minutes of meetings we reviewed demonstrated this.</li> <li>Clinical searches and records reviews showed that new and historic safety alerts were acted on. All patient safety alerts were uploaded on to a web-based platform to maintain oversight and increase accessibility for staff.</li> </ul>	

## Effective

**Rating: Good**

We inspected the practice in November 2021 and rated the practice Inadequate for effective services. There was no systematic, structured approach to the management of patients care and treatment including those with long term conditions. There was a lack of effective quality assurance systems and clinical oversight.

During this inspection we rated the practice Good for providing effective services. Patients with long term conditions were monitored and reviewed. The practice was proactive in following up and responding to patients who did not attend. There was comprehensive quality assurance system to assess the quality and safety of the service. The practice continued to monitor childhood immunisations and cervical screening rates, implementing strategies to improve the uptake.

*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.	
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
Explanation of any answers and additional evidence:	

Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed by auditing of prescribing practices and clinical consultation records. Our clinical searches and reviews of patient's records with long term conditions showed that patient's care, and treatment follow evidence-based practice for example, in the management of patients with asthma and diabetes.

## 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.
- 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 used the Gold Standard Framework (GSF) for end of life care.
- 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 including the social prescriber for support.
- A search of the clinical system demonstrated structured medicines reviews were carried out.

## Management of people with long term conditions

### Findings

- Individual care records were accurate and up to date to support the delivery of care for patients with long-term conditions. This enabled the practice to share clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Patients with long-term conditions were offered annual reviews to check their health and medicines needs were being met, this included structured medicines reviews. For patients with the most complex needs, the GP worked with other health and care professionals such as care homes and secondary care services to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Patients with asthma were reviewed and offered an asthma management plan. There were 558 patients on the practice's asthma register of these 61 patients had required two or more courses of rescue medicines in the last 12 months. We found the practice had reviewed these 61 patients to assess treatment and compliance. Patients were issued warning cards for their treatment and safety netting was in place.
- Our clinical searches indicated that patients on high risk medicines for long term conditions such as hypothyroidism and chronic kidney disease had appropriate monitoring in place.
- There were 886 patients with diabetes, of these 70 were high risk patients due to increased blood sugar levels and diabetic retinopathy (damage to the retina which, if not treated, can lead to loss of sight). We reviewed a sample of patients records and saw appropriate interventions had been made by the practice in response to the high blood sugar levels. This included review of insulin dosage and referral to diabetes specialist.

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)	102	110	92.7%	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)	81	92	88.0%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	81	92	88.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	81	92	88.0%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	93	108	86.1%	Below 90% minimum

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

### Any additional evidence or comments

- The practice had not met the minimum 90% for four of the five childhood immunisation indicators and therefore also not met the WHO based national target of 95% (the recommended standard for achieving herd immunity). This was identified as an area for improvement at the inspection in November 2021. However, there was an overall increase in uptake for immunisation rates for 2-year olds from 81-82% during the inspection in November 2021 (data for year 2019 to 2020) to 88% at this inspection (data for year 2020 to 2021). The uptake for 5 years old had significantly improved from 70% to 86%.
- The practice told us they continued to monitor and follow up non-attendance rates for childhood immunisation. Clinical capacity had been increased by one full time nurse and health care assistant per week and a phlebotomist who worked on a part time basis. This was in addition to a locum advance nurse practitioner (ANP) who worked regularly at the practice. There was a

lead nurse for childhood immunisations with support from a designated administrative staff to help monitor uptake.

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: 31/03/2022) (UK Health and Security Agency)	66.3%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.6%	55.7%	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)	51.4%	57.0%	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)	43.9%	50.3%	55.4%	No statistical variation

#### Any additional evidence or comments

- Cervical screening uptake was below the national target of 80%. This was identified as an area for improvement at the inspection in November 2021 when the uptake was 68.8% (Snapshot date: 31/03/2021). The practice told us of ongoing actions taken to help improve uptake. This included increasing clinical capacity by one full-time nurse and health care assistant and a phlebotomist who worked on a part time basis. There was now a lead nurse for cervical screening to maintain oversight with support from a designated administrative staff. A quality improvement activity was started in March 2022, to help target patients who had not attended with a focus on communities with lower participation rates. The aim was to promote uptake by providing patients with information and education, at the time of the inspection 38% of eligible patients had been contacted. The practice continued to offer flexibility with appointments which included dedicated clinics as well as opportunistically. A home visiting service was provided for housebound patients and there was active review of lists and appointment reminders to patients. However, at the time of the inspection this had not resulted in improvements.
- At the inspection in November 2021 the practice was below local and national averages for cancer detection rates of which resulted from a two week wait referral, at a negative variation of 32.8%. During this inspection the practice data showed that practice performance had improved to 43.9%. The practice had a named lead for cancer and all cancer diagnosis were reviewed. An audit had been completed on cancer diagnosis to review if correct pathways and protocols were followed and identify any learning. In addition to an audit on cancer two week wait

referrals to review referrals were actioned in a timely manner and safety netting systems were in place such as advising patients to contact the surgery if they did not received their appointment within a specified timeframe .

## 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

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

- The practice had commenced a programme of quality improvement activity to target areas for improvement identified at the inspection in November 2021. This included areas of medicine management and cancer screening. For example:
- An audit was completed to assess the prescribing of antibiotics in children aged 0-4 years between June 2021 and May 2022. The aim was to assess the appropriateness of prescribing and if prescribing was in line with local guidelines. The audit identified areas for improvement including the need to promote awareness of the use of delayed prescribing. Feedback of the audit findings was provided to prescribers to facilitate peer review and shared learning.
- An audit was completed based on a patient safety advice for medicine issued by the UK's Medicines and Healthcare products Regulatory Agency (MHRA). The purpose was to identify any patients prescribed this medicine to ensure patients were reviewed for risk and appropriate management plans were in place. The audit identified that all patients on this medicine had been reviewed appropriately. This demonstrated that actions taken by the practice to improve the system for recording and responding to safety alerts had been embedded.
- The provider carried out clinician consultation audits reviewing the quality of documentation against best practice standards. The consultation records of 10 clinicians were included in the audit with 20 consultations in total selected based on a selection of telephone and face to face consultations over a 12-month period. The audit identified areas of good practice such as the documentation of presenting complaints and in performing and documenting physical examinations. Areas for improvement included adding of quality outcome alerts and documentation of psycho-social history. Feedback was provided to clinicians and a repeat audit was scheduled.
- A number of other quality improvement activities had been commenced in areas such management of tasks and correspondences, end of life care and prescribing of psychotropics and opioid medicines.

### Any additional evidence or comments

- During this inspection there was evidence to support ongoing and sustained improvements in areas such as safeguarding, recruitment and medicine management. A search of the clinical system demonstrated improvements in patient care and treatment such as those with long term conditions and high-risk medicines.

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• A system was in place to monitor and review staff training and we saw a high levels of completion rates for training in core areas.</li> <li>• Discussion with clinical and non-clinical staff demonstrated awareness and understanding in areas such as safeguarding, consent and responding to an emergency.</li> <li>• There was evidence of staff appraisals and staff reported they were encouraged and given opportunities to develop for example, prescribing, specialist diabetes courses and training for advance clinical practice.</li> <li>• The practice had assurance systems and clinical oversight of allied health professionals including non-medical prescribers by the process of clinical supervision and audits of consultation and prescribing practice including decisions not to prescribe.</li> <li>• The practice was a designated practice for trainee GPs with the lead GP and more recently a salaried GP approved trainers. At the time of the inspection there was one trainee GP in post.</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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>A review of patient's records demonstrated effective communication and coordination between the practice and other services.</li> </ul>	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice worked with other services and organisations to support patients and ensure care was delivered in a coordinated way. For example, specialist and secondary services, care homes and the palliative care team.</li> <li>Patients were referred to the social prescriber to provide support.</li> <li>The practice proactively engaged with patients and followed up non-attendance for health and medication reviews.</li> </ul>	

- Findings from our clinical searches and reviews of patient records demonstrated that patients had access to health assessments and reviews such as for asthma and diabetes.

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• A provider policy for consent and Mental Capacity Act was in place. Verbal consent was recorded in patient records and where appropriate written consents forms were in use for example, minor surgical procedures.</li> <li>• Staff had received training in consent, dementia awareness and the Mental Capacity Act. There were policies in place to support good practice.</li> <li>• There was an ongoing quality improvement programme to review and update Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions, this included liaising with health and social care professionals. A sample of patient records we reviewed showed DNACPR decisions were appropriate. For example, the rationale for the decision was clear and discussion with the person and /or their representative was recorded.</li> </ul>	

# Caring

Rating: Good

## Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgmental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>Discussions with staff demonstrated understanding and awareness of the importance of person-centered care. Staff had received training in equality and diversity.</li><li>There were information and support within the practice and on the website, sign posting patients to various support services.</li></ul>	

Patient feedback	
Source	Feedback
NHS Website	There were no new reviews since the last comprehensive inspection in November 2021, there were two reviews completed in November 2021 which were positive about staff and the care and treatment received.
NHS Friends and Family Test	Results for June 2022, showed of the 202 responses, 161 patients who completed the survey said they would recommend the practice, compared with six who would not recommend and two who were not sure.
CQC Enquiries	We received two negative pieces of feedback since the last comprehensive inspection in November 2021, which included perceived poor attitudes of the staff.

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	85.9%	78.9%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	79.5%	76.9%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	93.2%	89.4%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	68.8%	62.2%	72.4%	No statistical variation

### Any additional evidence or comments

- At the time of the inspection, the national GP survey results for the period 01/01/2022 to 30/04/2022 had recently been published. The results showed the practice was mostly above local and similar to national averages for patient satisfaction in questions related to caring.

### Question

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

Y/N

N

### Any additional evidence

- Feedback from patients had been gathered through the NHS website, the NHS Friends and Family Test (FFT) and comments and complaints received.
- The practice patient participation group (PPG) had recently re-established with new members joining following a campaign promoting for membership. Meetings had taken place where the results of the recent national GP survey had been discussed, it was acknowledged that whilst the

results were positive there was potential for further improvements and plans were in progress to develop an in-house survey to obtain feedback at practice level.

### Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was information and support within the practice and on the website, sign posting to various services such as support for carers.</li> <li>• Easy read and pictorial materials were available on request.</li> <li>• The practice had access to a social prescriber employed within the Primary Care Network (PCN) who undertook sessions at the practice. Patients were referred for support with their health and wellbeing.</li> </ul>	

Source	Feedback
NHS Website	There were no new reviews since the last comprehensive inspection in November 2021, two reviews completed in November 2021 were positive about staff and the care and treatment received.
NHS Friends and Family Test	Results for June 2022, showed of the 202 responses, 161 patients who completed the survey said they would recommend the practice, compared with six who would not recommend and two who were not sure.
CQC Enquiries	We received two negative pieces of feedback since the last comprehensive inspection in November 2021, which included perceived poor attitudes of the staff.

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	93.1%	85.1%	89.9%	No statistical variation

### Any additional evidence or comments

- At the time of the report, the most recent national GP survey results for the period 01/01/2022 to 30/04/2022 had just been published. The results showed the practice was above local and national averages for patient satisfaction in questions related to involvement in decisions about care and treatment.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice website had information on health and wellbeing with links to various groups such as domestic abuse, mental health and bereavement services.</li> <li>There was an induction loop system within the practice to assist people with hearing impairment.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	490 (5%) of the practice list were identified as carers.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>• The practice had a register to ensure all carers were easily identified and could be offered an annual health assessment, the flu vaccination and support and advice.</li> <li>• There was information available on the practice website and in the patient waiting area signposting carers to support groups and encouraging carers to identify themselves, so support could be offered.</li> <li>• Staff had received carer awareness training.</li> <li>• The practice had a carer's champion to coordinate identification and support within the practice.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>• The practice contacted patients to offer support and referred patients to support services and bereavement counselling where necessary.</li> <li>• Patients receiving end of life care were on the palliative care register.</li> <li>• There were regular meetings with the palliative care team to ensure information was shared and that support could be offered to carers who were also included on the carers register.</li> <li>• There was information available on the practice website on bereavement services.</li> </ul>

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

# Responsive

Rating: Good

## Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>During the inspection in November 2021, we saw some parts of the premises were in need of repair and upgrade such as the carpets in the patient waiting area and the ceiling in an administrative room. The practice told us at the time there were ongoing discussions with the landlord to address these issues. At this inspection we saw improvements. The practice had started a programme of replacing carpets prioritising clinical areas, the ceiling in the administrative room and the roof in the foyer had been repaired. There were ongoing discussions with the landlord for further improvements.</li> <li>There were lead staff for accessible standards who had received specific training.</li> <li>There was no designated baby changing facilities; staff reported a room was made available on request.</li> </ul>	

Practice Opening Times	
Day	Time
<b>Opening times:</b>	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	7am to 1pm, closed pm *when the practice is closed during the core hours of 1pm to 6.30pm cover is provided by a GP service contracted by the practice



Thursday	7am to 6pm  *when the practice is closed during the core hours of 6pm to 6.30pm cover is provided by a GP service contracted by the practice
Friday	8am to 4pm  *when the practice is closed during the core hours of 4pm to 6.30pm cover is provided by a GP service contracted by the practice
<b>Extended opening:</b>	Wednesday 7am to 8am Thursday 7am to 8am
<b>Appointments available:</b>	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	7am to 1pm  *when the practice is closed during the core hours of 1pm to 6.30pm appointments provided by a GP service contracted by the practice
Thursday	7am to 6pm  *when the practice is closed during the core hours of 6pm to 6.30pm appointments are provided by a GP service contracted by the practice
Friday	8am to 4pm  *when the practice is closed during the core hours of 4pm to 6.30pm appointments are provided by a GP service contracted by the practice

#### Further information about how the practice is responding to the needs of their population

- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Appointments were available outside school hours.

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Longer appointments were offered, and home visits were available for health checks and blood tests.
- Care and treatment for people approaching the end of their life was coordinated with other services. An audit was in progress to review and update any decisions on end of life care for patients.

## 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:	

- A range of appointments were offered including on the day and pre-bookable and included online, video and telephone consultations.

### National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	55.6%	43%	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	57.9%	46.1%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	58.3%	48.6%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	79.3%	64.8%	71.9%	No statistical variation

### Any additional evidence or comments

- The recent national GP survey results showed the practice was above local and national averages for patient satisfaction in questions related to access.

Source	Feedback
CQC Enquiries	Since the comprehensive inspection in November 2021, we received three pieces of feedback in relation to difficulties getting through to the practice by telephone and access to appointments.

## Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	Five
Number of complaints we examined.	Three
Number of complaints we examined that were satisfactorily handled in a timely way.	Three
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff had received complaints training.</li> <li>• There was a complaints procedure and information for patients on how to raise a complaint was available in the practice. There was information on the website on submitting general feedback however, no specific information on complaints.</li> <li>• Complaints were discussed with staff during team meetings and relevant learning shared.</li> <li>• Information on the Parliamentary and Health Service Ombudsman was included in final responses to complainants.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Issuing of repeat prescription	Apology and explanation given to the patient, incident treated as significant event with actions taken to reduce reoccurrence and learning shared.

## Well-led

**Rating: Good**

We inspected the practice in November 2021 and rated the practice Inadequate for well-led services as there was no formal system in place to assess and monitor the governance arrangements. The practice did not have fully embedded assurance systems and had not proactively identified and managed risks. Leaders could not demonstrate that they had the capacity to deliver high quality sustainable care.

During this inspection we rated the practice Good for providing well-led services. The provider had implemented formal systems to assess and monitor the governance arrangements. There were comprehensive quality assurance systems to assess the quality and safety of the service. Changes were fully embedded and could be demonstrated by improvements in patient care and treatment. Leadership capacity had been increased and there was a commitment to ongoing improvements.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• Leaders understood and acknowledged the challenges impacting on the delivery of the service including findings of previous inspections. A business development plan and strategy was in place to address all areas for improvement. There was evidence of improvements in areas such as the monitoring of patients on high-risk medicines, management of patients with long term conditions and safeguarding.</li><li>• As part of plans to increase leadership capacity and succession planning a new partner was recruited with the Care Quality Commission (CQC) registration process currently in progress.</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>Staff told us they wanted to ensure patients received a good standard of service. The aim was to deliver high quality care and promote good outcomes for patients. During this inspection the practice demonstrated improvements with systems and processes to ensure the vision and values were monitored and could be delivered consistently.</li> </ul>	

## 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>There was an emphasis on staff wellbeing, and this was demonstrated through discussions with staff.</li> <li>Policies were in place for whistle blowing and a delegated speak up guardian which allowed staff to understand the process and refer any concerns.</li> <li>Team meetings took place and provided an opportunity for staff to discuss issues.</li> </ul>	

- Staff said they were confident to raise any concerns and felt they would be listened to.

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

Source	Feedback
Staff interviews	Staff were positive about the practice team and the changes implemented to improve patients care and treatment and the overall experience of the service. This had increased morale. Staff said leaders were approachable and supportive.

### Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Communication systems and oversight were developed and cascaded from leaders to staff.</li> <li>• The governance arrangements had been strengthened. There was a quality assurance protocol and a Governance Framework Performance meeting every six months to monitor audits and assessments. A clear organisational structure was in place and lead roles outlined.</li> <li>• The practice used a web-based platform to maintain oversight of areas such as patient safety alerts and policies and procedures. This also ensured staff had access to up to date information.</li> <li>• Discussions with staff showed understanding and awareness of key policies such as safeguarding and whistleblowing. We looked at a sample of policies and saw they had been reviewed and were up to date.</li> </ul>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There were comprehensive assurance systems to effectively identify and manage risks, this included a programme of quality improvement activity and audits. Areas for improvement were identified and addressed. This included areas of safeguarding and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.</li> <li>• Although a major incident plan was in place, staff had not received training in preparation for a major incident. However, our discussion with staff showed they were aware of what to do in the event of a major incident.</li> </ul>	

**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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice told us that during the pandemic, there were systems in place to ensure patients who needed to be seen face to face were given appointments to attend the surgery. This was done with consideration for COVID-19 guidance for infection prevention and control procedures.</li> <li>• Searches of the clinical system showed the practice had implemented systems and processes to ensure structured medicine reviews and the monitoring of patients on high risk medicine and those with long term. High risk and vulnerable patients were prioritised.</li> <li>• There were ongoing infection prevention and control audits to monitor quality and safety.</li> </ul>	

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The systems in place to monitor performance had been embedded, this was demonstrated by improvements in patient care and treatment supported by findings of clinical searches undertaken and reviews of patient records.</li> <li>• The service had submitted any required notifications to the Care Quality Commission (CQC) in line with requirements of regulation.</li> </ul>	

## 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
Explanation of any answers and additional evidence:	
<p>A policy was in place for remote access, video consultation and information governance. These included the process and procedures for telephone, email and video consultations which included verifying identity and consent.</p> <ul style="list-style-type: none"> <li>The provider had a Data Protection Impact Statement in place to support the use of remote consultation. This included the processing of patient data, compliance and proportionality measures with reference to NHS best practice guidelines.</li> </ul>	

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	

- Since the last inspection, the practice had actively promoted the Patient Participation Group (PPG) following which there was renewed interest with 12 new members joining. There had been two meetings held and a number of areas were discussed to help improve patients experience of the service. This included a television to enable health information to be promoted in the patient waiting area, repairing the self-check in system and a patient call system so clinicians do not have to physically call patients in for their appointments.
- The practice worked with the local primary care network (PCN) and the Integrated Care Board (ICB) to deliver services for the local practice population which included services to care homes and supporting people living with frailty within the PCN.

#### Feedback from Patient Participation Group.

##### Feedback

- We spoke with one member of the PPG, they told us the group was relatively new however, they were keen to work with the practice to improve the service. The practice was responsive to feedback and suggestions and this was supported by meaningful discussions in meetings. Actions taken to date in response to feedback included repairing the self-check in service and allocating dedicated hours each day for patients to order prescriptions with the aim to reduce the amount of time people were waiting on the telephone system to order prescriptions.

#### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Learning and improvement was encouraged through staff appraisals, meetings and training.</li> <li>• The practice made effective use of internal and external reviews of incidents such as significant events, complaints and patient safety alerts.</li> </ul>	

##### Examples of continuous learning and improvement

- Clinical audits were completed and provided the opportunity to learn and improve for example, in the areas of medicine management. We saw improvements in patients care and treatment.

- Non-clinical audits were completed in areas of infection prevention and control, health and safety and safeguarding.

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

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

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

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

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

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

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

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