

Inspection Evidence Table

Dr Cotterell and Partners

(1-571364138)

Inspection Date: 8 August 2023

Date of data download: 28/07/2023

Overall rating: Requires Improvement

We rated the practice as requires improvement overall because systems and processes were not always implemented. The systems in place for good governance and management were not always effective.

Safe

Rating: Requires Improvement

We rated the practice as requires improvement for providing safe services because:

- Medicine reviews were not always completed comprehensively.
- Staff were not always informed of the outcome of significant events.
- Relevant safety alerts were not always responded to.

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: One of the GP partners was the safeguarding lead for the practice. We were informed they were supported by the local primary care network (PCN) safeguarding lead. Staff we spoke with were aware of who this was and safeguarding policies contained contacts for the local authority safeguarding teams. All of the clinical staff in the practice were trained to safeguarding level 3. Non-clinical staff were trained to level 2. Alerts were used on the clinical system to identify patients and their families if there was a safeguarding concern. These alerts were visible to the Out of Hours service if a patient was seen out of practice working hours.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence: The practice used a local occupational health department for support in ensuring staff vaccinations were maintained.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: July 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: July 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence: The practice had fire marshalls in place and had carried out a fire drill in July 2023. The evacuation procedure and fire assembly points were displayed on the walls in the practice.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y

Date of last infection prevention and control audit: June 2023	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> <p>The practice had consulted with the infection prevention and control (IPC) lead from Northamptonshire Integrated Care Board (ICB) to complete an audit and identify actions required. The practice stopped carrying out minor surgery while improvements were made.</p> <p>There was a lead GP and a lead nurse for ICP. In addition to carrying out an annual IPC audit they audited the practises of staff members including hand washing, the use of personal protective equipment (PPE) and the use of aseptic technique when carrying out procedures. Aseptic technique is a way to carry out procedures to minimize contamination.</p> <p>An external cleaning company was used and cleaning schedules had been updated following the IPC audit to ensure appropriate standards of cleaning were maintained. We observed the practice to be visibly clean and tidy.</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
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the inspection there was a vacancy for a practice manager. The practice was receiving support from neighbouring practices to provide management cover. A practice manager had been recruited following the inspection.</p> <p>There were prompts in the clinical rooms and reception area to remind staff of red flag symptoms to be aware of for patients who may have sepsis.</p> <p>Emergency equipment was easily accessible.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y

There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, they were not always implemented.

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.77	0.93	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) (NHSBSA)	7.4%	7.4%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) (NHSBSA)	5.45	5.12	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	78.1‰	134.2‰	129.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.43	0.56	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	4.8‰	7.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
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The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	N
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.	Partial
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.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>Processes were in place for structured medicines reviews for patients on repeat medicines. However, we reviewed the clinical records for patients and found the provider recorded medicine reviews had been conducted without documenting the outcomes from the review and without addressing required monitoring or changes to treatment that should have been identified during a comprehensive review. The medicines reviews did not identify that patients had been prescribed medicines that were subject to safety alerts.</p> <p>The process for monitoring patients' health in relation to the use of medicines including high risk medicines was generally well managed. However,</p> <ul style="list-style-type: none"> We reviewed 4 patients who had been prescribed an immunosuppressant medicine used to treat inflammatory conditions. All of these patients had been monitored appropriately; 3 of the patients did not have the stated day of the week they should take their medicine according to current guidelines. 	

- There were 4 patients out of 217 prescribed direct oral anticoagulants (DOAC), a high-risk medicine used as an alternative warfarin, who despite having had appropriate blood tests, had not had a creatinine clearance calculated which is necessary to determine safe dosing of the medication.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services: The lead GP for the dispensary was responsible for ensuring the Standard Operating Procedures were reviewed and followed by dispensing staff. Access to the dispensary was restricted to dispensing staff and GPs only. Appropriate security measures were in place for the storage of controlled drugs. All dispensing was checked by two staff members to avoid any mistakes being made. Learning was evident from the recording of dispensing incidents and near misses. For example, medicines with similar names were not stored together.</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.	Partial
Number of events recorded in last 12 months:	5
Number of events that required action:	5
Explanation of any answers and additional evidence: We were informed significant events were discussed at clinical meetings and relevant information was cascaded to staff via individual managers. We reviewed minutes of clinical meetings that showed significant events had been discussed. Feedback from staff indicated they were not always given feedback of significant events that had occurred.	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Information from a hospital discharge letter was not followed and a patient was prescribed the incorrect dose of a medicine.	The patient was informed of the error and the correct dose of medicine was prescribed. No harm had come to the patient. Clinicians were advised to be vigilant when carrying out instructions from discharge letters and when selecting pre-populated doses on the clinical system. They were advised to use alerts on the clinical system to record changes had been made.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: The practice had a system in place for managing safety alerts that was supported by the clinical pharmacist from the primary care network (PCN). However, a remote review of the clinical system showed the provider was unable to demonstrate that all relevant safety alerts had been responded to. For example, <ul style="list-style-type: none"> we saw that 8 patients remained on a dose of a medicine used to treat depression that increased their risk of heart problems. We reviewed 5 of these patients and found there was nothing in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered. a review of the patient record system identified 17 patients prescribed a combination of a medicines used to treat those who have had a stroke or heart attack to reduce their chances of having a further one, and a medicine used to reduce stomach acid. A safety alert issued in 2014, advised that these medicines should not be prescribed together as the medicine used to reduce the chance of having a stroke was made less effective. Prior to the inspection, the practice had carried out a search of their clinical system that identified that patients prescribed this medicine required a review, they had not taken steps at that time to review the patients. Following the inspection, we were informed that patients had been contacted for a review of their treatment.	

Effective

Rating: Requires Improvement

We rated the practice as requires improvement for providing effective services because:

- The uptake for cervical screening was below the 80% target set by the UK Health Security Agency.
- There was minimal quality improvement activity. The practice had put an action plan in place. However, at the time of the inspection it had not been fully implemented.

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
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: The practice had systems in place to keep all clinical staff up to date. Staff had access to clinical templates and National Institute for Health and Care Excellence (NICE) best practice guidelines. They used this information to deliver care and treatment that met patients' needs.	

Effective care for the practice population

Findings

- 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 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

A remote review of the patient record system showed that patients generally had received appropriate long-term condition reviews and the practice had followed up patients who had received treatment in hospital or through the out of hours service. For example,

- There were 32 patients diagnosed with asthma who had been prescribed 2 or more courses of rescue steroids and had received an appropriate review. We reviewed 5 patients and found 1 patient had not been issued with a steroid card when would have been appropriate to do so. Steroid cards are issued to provide information on emergency treatment if the patient is acutely ill, experiences trauma, surgery or other major stressors when patients have repeated courses of steroids.
- There were 23 patients diagnosed with chronic kidney disease. Our remote review of the patient record system indicated 1 patient had not received appropriate monitoring. The practice reviewed this patient and blood tests were arranged via the hospital, but the provider had not routinely recorded that these were carried out elsewhere.
- There were 334 patients diagnosed with hypothyroidism and we found they had all received appropriate blood monitoring.
- There were 24 patients diagnosed with diabetic retinopathy who had a high average blood glucose level. We reviewed 3 of these patients and found they had all received appropriate monitoring.

Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

Staff who were responsible for reviews of patients with long-term conditions had received specific training. GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

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.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	55	57	96.5%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	61	62	98.4%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	61	62	98.4%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	61	62	98.4%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	66	69	95.7%	Met 95% WHO based target

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

Any additional evidence or comments
The practice ran weekly childhood immunisations clinics. They adjusted the frequency if any back logs occurred. The nursing team were supported by the administration team to contact the parents or guardians of children not brought in for their immunisations. The practice had exceeded the World Health Organisation (WHO) target for all child immunisations.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	69.4%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	74%	N/A	70.3%	N/A

The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (12/31/2022 to 12/31/2022) (UKHSA)	77.4%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	52.6%	56.5%	54.9%	No statistical variation

Any additional evidence or comments

The practice were aware they were below the 80% target set by the UK Health Security Agency for the uptake of cervical screening. Additional staff were being trained to carry out cervical screening and text messages were used to remind eligible patients that they should attend for screening. Extended access appointments were available for eligible patients to attend in the evening or weekend for cervical screening.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

	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.	Partial
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 a quality improvement plan in place that covered clinical and administrative processes in the practice. The practice had identified there had been minimal clinical audit activity and prior to the inspection had implemented a clinical audit action plan. Audits to be completed had been identified with a timeframe and which staff member would carry out them. An audit had been carried out to ensure controlled drugs were stored correctly following current guidance. Following the first cycle of the audit a meeting was held with the lead GP for the dispensary and the dispensary team to review identified actions. A second cycle audit found that controlled drugs were stored appropriately. Standard operating procedures were in place to provide guidance for staff.	

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.	Partial
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: All staff had access to online platforms to complete training required for their roles. Feedback from staff showed that regular appraisals did not always take place. There had been some changes to the practice management prior to the inspection and we were informed appraisals would take place in the future.	

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: The practice had regular meetings, with community staff to discuss patients with complex needs or those who were receiving palliative care.	

Helping patients to live healthier lives

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

	Y/N/Partial
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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
<p>Explanation of any answers and additional evidence: The practice had access to a social prescriber through the primary care network who they could refer patients to for extra support. Patients were signposted to healthy living and smoking cessation support organisations.</p>	

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: Our clinical review of notes where a DNACPR decision had been recorded, identified where possible the patients views had been sought and respected. We saw that information had been shared with relevant agencies.</p>	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	Y/N/Partial
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Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental 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: Staff had received Equality and Diversity training. Support was in place for patients who had received a terminal diagnosis that involved a review of the care received and liaison with community staff.	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	88.8%	83.0%	85.0%	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 (01/01/2023 to 30/04/2023)	82.8%	82.7%	83.8%	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 (01/01/2023 to 30/04/2023)	94.0%	91.4%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	67.2%	69.4%	71.3%	No statistical variation

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

Any additional evidence

The practice used the NHS Friends and Family Test (FFT) to gather feedback from patients. The FFT was created to help providers understand whether patients were happy with the service provided or where improvements were needed.

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
Explanation of any answers and additional evidence: Interpretation services were available for patients who did not speak English. The practice displayed information about local services and support available to patients. Easy read materials were available.	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	87.9%	88.3%	90.3%	No statistical variation

	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

Carers	Narrative
Percentage and number of carers identified.	There were 173 patients identified as carers which equalled approximately 2% of the practice population.
How the practice supported carers (including young carers).	Patients who were carers were identified and a flag placed on their clinical record so staff were aware they may need additional support. The practice had a social prescriber who was available for support information. Patients were asked when they registered with the practice if they were a carer. Young carers were identified at palliative care and multidisciplinary meetings.

How the practice supported recently bereaved patients.	An appointment with a GP was offered to these patients. Information on support organisations to help patients when bereaved was available.
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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

Responsive

Rating: Requires Improvement

We rated the practice as requires improvement for providing responsive services because:

- Feedback from patients via the National GP Patient survey was negative regarding telephone access and appointment booking.
- The practice had taken some actions to improve telephone access and appointment booking and had plans to change their telephony system. However, it was too soon to assess the impact of these measures.

We recognise the pressure that practices are currently working under, and the efforts staff are making to maintain levels of access for their patients. At the same time, our strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. Although we saw the practice was attempting to improve access, this was not yet reflected in the GP patient survey data or other sources of patient feedback. Therefore, the rating is requires improvement, as ratings depend on evidence of impact and must reflect the lived experience that people were reporting at the time of inspection.

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: The practice had an understanding of their patient population and the local area.	

They worked as part of a Primary Care Network (PCN). PCNs are groups of GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their areas to provide local services.

The practice was on one level with easy access for patients with a disability.

There was ample parking and designated spaces for patients with disabilities close to the building. There were access enabled toilets and baby changing facilities.

Practice Opening Times

Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

Appointments were available throughout these times.

Home visits were available for housebound patients.

Appointments were also available via the East Northants GP Extended Access Hub on Monday to Friday from 6.30pm to 8pm and on Saturday from 9am to 5pm. These appointments were available either at the practice or a neighbouring practice.

Dispensary Opening Times

Day	Time
Opening times:	
Monday	10am to 12pm and 4pm to 6pm
Tuesday	10am to 12pm and 4pm to 6pm
Wednesday	10am to 12pm and 4pm to 6pm
Thursday	10am to 12pm and 4pm to 6pm
Friday	10am to 12pm and 4pm to 6pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- 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.
- Seasonal immunisations were offered via a home visit for housebound patients.
- There was disabled access at the practice.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Appointments were available outside of school hours for children.
- Appointments could be booked by telephone or online. Prescription requests were available online.

- Email and text messages were used to communicate with patients who were hard of hearing.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

People were not always able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence: Patients could book appointments by telephone or via online services. There were protected appointments for patients that had accessed healthcare via the NHS 111 service. Appointments were available either face to face, online or by telephone. Longer appointments were available for patients with multiple conditions or complex needs.	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	35.9%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	41.9%	50.8%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with	39.3%	50.1%	52.8%	No statistical variation

their GP practice appointment times (01/01/2023 to 30/04/2023)				
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	69.3%	71.4%	72.0%	No statistical variation

Any additional evidence or comments

The practice was aware of the National GP Patient survey scores in relation to telephone access and appointment booking. They had made plans to update the practice telephony to a cloud based system that would enable better management of calls coming into the practice. They had added telephone access and appointment booking to their Quality Improvement plan and identified actions to take. This included making use of the extended access service to book appointments for example, for long term condition reviews and cervical screening. The practice had recruited an additional advanced nurse practitioner to help meet demand for appointments.

Source	Feedback
NHS.uk website (formerly NHS Choices)	At the time of the inspection there had been no reviews about the practice on the NHS website. Following the inspection there was 1 negative review from a patient regarding telephone access to make an appointment.

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.	10
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Examples of learning from complaints.

Complaint	Specific action taken
Delay in completing a travel insurance form. The patient had been advised the form would be completed within 2 weeks which was not achieved.	The practice manager ensured the form was completed. Staff were advised to follow the correct process and give a realistic timeframe for completion of insurance documents.

Complaint that symptoms were not investigated fully.	The GP reviewed the clinical notes and found appropriate investigations had taken place. An additional test that could have been made was not available at the time due to the patients age. The practice raised this with the local Integrated Care Board to see if the test could be made available.
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Well-led

Rating: Requires Improvement

We rated the practice as requires improvement for providing well-led services because:

- Staff reported they did not always feel supported by the GPs and practice management.
- There was a lack of oversight to ensure policies and procedures regarding medicines management and effective management of patients was applied.
- The provider was unable to demonstrate effective clinical oversight to ensure all relevant safety alerts had been responded to.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels but it was not always effective.

	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.	N
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The practice was aware of the challenges they faced and had a quality improvement plan in place. At the time of the inspection the practice were in the process of recruiting a new practice manager. Feedback from staff was that communication with GPs and management was not always sufficient and they did not always feel included. For example, staff felt that more team meetings to share information would be beneficial.	

Vision and strategy

The practice had a clear vision, but it was not supported by a 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.	Partial
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: The practice had a vision, values and strategy in place but were aware staff did not always feel involved in the planning of this. They reported they wanted to put staff at the centre of their vision going forward.	

Culture

The practice culture did not always effectively support 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.	N
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: Staff reported they did not always feel supported by the GPs and practice management. However, they did report they felt able to speak up when required. The practice had a Freedom to Speak Up Guardian who was external to the practice and arranged through the Primary Care Network.	

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

Source	Feedback
Staff feedback forms and staff interviews.	Feedback from staff was mixed. Staff reported that they did not always feel supported. Some staff alleged there had been a downturn in how the practice was managed in the previous few years. However, there were comments that they could see improvements had started to take place. Staff have not felt involved with the practice development and plans for the future.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, they were not always effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: The practice used policies and procedures to govern their work. However, there was a lack of oversight to ensure policies and procedures regarding medicines management and effective management of patients was applied. All staff had access to the policies and procedures in place.	

Managing risks, issues and performance

The practice did not always have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: Processes for medicines reviews were not always followed. The provider was unable to demonstrate effective clinical oversight to ensure all relevant safety alerts had been responded to. Following the inspection, we were informed a clinical pharmacist from the primary care network was working with the practice to complete medicine reviews. There was a quality improvement plan and a clinical audit action plan in place. However, the clinical audit action plan had yet to be fully implemented.	

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: The practice used the Quality and Outcomes Framework (QOF) to manage performance.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

Engagement with patients, the public, staff and external partners

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

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

Explanation of any answers and additional evidence:
 The practice had a Patient Participation Group (PPG) that met every 8 weeks.
 The PPG had a dedicated noticeboard in the patient waiting area to display information for patients about the group.
 The practice worked closely with the Primary Care Network to provide care.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice had protected time for learning. They made use of significant event analysis and complaints to learn and make improvements. Prior to the inspection the practice had worked with the Northamptonshire Integrated Care Board and identified actions to be taken to make changes to the practice. They had implemented a Quality Improvement Action Plan to monitor and complete the actions.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

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

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

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

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

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

Glossary of terms used in the data.

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