

Care Quality Commission

Inspection Evidence Table

Blundell Park Surgery (1-5783669093)

Inspection date: 8 and 9 September 2021

Date of data download: 20 September 2021

Overall rating: Requires Improvement

We inspected the practice on 9 July 2019 and rated the practice Inadequate overall. The practice was put into special measures and enforcement action was taken.

We followed up the enforcement action with an announced focused inspection on 4 December 2019. We found that the practice had made some improvements in relation to the breaches in regulation.

We inspected again on 26 February 2020 and found that some of the improvements we saw in the follow-up inspection had not been sustained and in addition we found some other areas of concern. The practice was rated as requires improvement overall and requires improvement for the key questions safe and effective, good for caring and responsive and inadequate for well led and the practice remained in special measures.

At the inspection on 18 November 2020 we rated the practice as requires improvement overall and in population groups, people with long term conditions, families, children and young people and working age people. The practice had made improvements since our inspection in February 2020 and addressed areas relating to previous breaches of regulation. However, we had found additional areas of concern.

We inspected the practice again on the 8 and 9 September 2021. We found some improvements had been made in management oversight, recruitment and health and safety since the last inspection and the environment had been improved following a programme of refurbishment. However, some areas had not been adequately improved and the practice is rated Requires Improvement overall and in safe, effective, caring and well led key questions and population groups for people with long term conditions, families, children and young people and working age people. They are rated Good for responsive services and all other population groups.

- The practice had implemented the actions from the fire and Legionella risk assessment actions except monthly checks of the emergency lighting and monthly testing of hot water temperatures.
- Whilst there had been some improvements in care and treatment provided compared to the last inspection, such as in the management of diabetes, there were still some areas of concern relating to effective monitoring and review of patients prescribed high risk drugs or with long term conditions.
- Some performance data was below local and national averages in relation to care and treatment of patients with long term conditions, cancer screening and childhood immunisations. Data also showed patient satisfaction had further deteriorated.
- Some patient records relating to medicine reviews and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were inconsistently completed or lacked detail.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Requires Improvement

When we inspected the practice on 9 July 2019, we rated the practice inadequate and following inspections in December 2019 and February 2020, practice was rated requires improvement for providing safe services because policies and procedures regarding safeguarding, medicines management, infection control and health and safety risk assessments were not effective.

At the inspection on 18 November 2020 improvements had been made in relation to the previous breaches of regulation. However, we rated the service requires improvement for providing safe services because we found additional areas of concern in relation to the management of Legionella, standards of cleanliness and hygiene and safe use of medicines.

At the inspection in September 2021 we found some improvements had been made in relation to the management of Legionella, standards of cleanliness and safe use of medicines. However, we have rated the practice as requires improvement because of the following areas of concern:

- Checks of the emergency lighting and hot water temperatures had not been completed.
- A staff toilet had no hot water facility for hand washing.
- Practice protocol had not always been followed in resetting the equipment to monitor the vaccine fridge temperatures.
- Some medicine review records lacked detail and still did not always document any changes or reasons for continuing the medicines.
- Some patients prescribed high risk medicines had not had the required monitoring checks and prescriptions were issued without ensuring this had been completed.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	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
Staff who acted as chaperones were trained for their role.	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

Safeguarding	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the inspections in February and November 2020 we found:</p> <ul style="list-style-type: none"> Newly recruited staff had not always had a DBS check completed by the provider prior to commencing employment. A risk assessment had not always been undertaken in respect of this. <p>At the inspection in September 2021:</p> <ul style="list-style-type: none"> We looked at three staff recruitment files and found all had had DBS checks completed. Due to delays related to the covid pandemic one member of non-clinical staff had started work prior to receipt of the DBS but a risk assessment had been completed. We found staff had completed children and adults safeguarding training. Three new staff had not completed this since starting at the practice. However, two of these staff had provided certificates to show their training had been completed in their previous employment and was up to date and the third person had a training plan in place. We saw registers for vulnerable and looked after children were in place although these were not linked to their parents/guardian's records. 	

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 Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the inspections in February and November 2020 we found:</p> <ul style="list-style-type: none"> Not all the required recruitment checks had been obtained such as references and professional registration checks. <p>At the inspection in September 2021:</p> <ul style="list-style-type: none"> We looked at three staff recruitment files and found all the required checks had been completed. We saw evidence of up to date registration checks for GPs and nurse working at the practice. 	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test: 11/2/21</p>	Y
<p>There was a record of equipment calibration.</p> <p>Date of last calibration: 11/2/21</p>	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y

There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: Full risk assessment completed 10/09/19 and an annual review had been completed 28/09/2020.	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the November 2020 inspection we found:</p> <ul style="list-style-type: none"> • Fire records did not include checks of the emergency lighting. • The fire records showed that checks of the fire alarm were carried out but not at the recommended weekly frequency. <p>At the September 2021 inspection:</p> <ul style="list-style-type: none"> • We found weekly fire alarm checks had been completed. • Emergency lighting maintenance check had been completed but they had not implemented the monthly checks. The practice manager stated this would be implemented immediately. <p>Evidence provided after the inspection showed the emergency lighting checks were implemented on the day of the inspection.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 17/11/2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 11/2020	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in November 2020 we found:</p> <ul style="list-style-type: none"> • Actions to minimise the risks related to fire and Legionella had not been completed as recommended in the risk assessments. A written environmental risk assessment in relation Covid-19 had not been completed although systems were in place to minimise risk. <p>At the September 2021 inspection:</p> <ul style="list-style-type: none"> • We found action had been taken as recommended in respect of the legionella risk assessment and records were maintained. Recommended maintenance requirements had been implemented other than monthly testing of the hot water temperatures. The practice manager said these would be implemented immediately. • A written Covid 19 risk assessment had been completed which showed control measures in place. <p>Evidence provided after the inspection showed monthly water temperature testing had been implemented on the day of the inspection.</p>	

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Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
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: 17/11/2020 Evidence provided after the inspection showed an additional audit had been completed on 12 October 2021.	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the November 2020 inspection we found:</p> <ul style="list-style-type: none"> We found some areas for improvement, there was an area of damp on a wall in the nurse's room, blinds in consultation rooms and the waiting room were in poor condition, a written risk assessment for IPC and hand washing assessments/training had not been completed and the risk assessment for the changing of privacy curtains required updating. <p>At the September 2021 inspection:</p> <ul style="list-style-type: none"> We observed improvements had been made. A refurbishment of the practice had been completed with clinical grade flooring and issues with damp addressed. Improvements had been made to blinds, and a risk assessment, in line with updated CQC guidance for privacy curtains, had been implemented. Hand washing training had been provided by the nurse. A written Covid 19 risk assessment had been completed which showed control measures in place. The assessment stated mitigation actions relating to the staff covid risk assessments had been discussed and agreed but there was no record of this. There were several patient and staff toilet facilities in the practice. We were told the facilities on the first floor were not in use. We observed that a staff toilet on the ground floor close to the staff kitchen had no hot water facility for hand washing. <p>Evidence provided after the inspection showed an additional IPC audit had been completed on 12 October 2021 by an IPC specialist nurse and the practice had achieved 96% compliance.</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
<p>Explanation of any answers and additional evidence:</p> <p>At the November 2020 inspection we found:</p> <ul style="list-style-type: none"> Some staff had left, and additional reception staff and an additional practice nurse had been employed. However, staff told us they felt there was still insufficient cover for absences and holidays. <p>At the September 2021 inspection:</p> <ul style="list-style-type: none"> We found the additional practice nurse employed prior to the last inspection had left. Two additional reception staff and an experienced health care assistant had been recruited since the last inspection. Staff told us they felt the staffing had improved to adequate levels to ensure cover. 	

Information to deliver safe care and treatment

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

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

discussed the incident in meetings, recruited additional administration staff and provided staff training.

Appropriate and safe use of medicines

The practice did not have 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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.73	0.79	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	6.0%	9.5%	10.0%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	5.59	5.76	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	178.5‰	158.8‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	1.89	0.61	0.65	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	10.4‰	7.2‰	6.8‰	No statistical variation

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

Any additional evidence or comments

Above average prescribing of hypnotics had been highlighted during the July 2019 inspection.

At the inspection in November 2020 we found:

- There had been little improvement in the data for prescribing relating to urinary tract infections and hypnotics. An audit for prescribing of a hypnotic medicine had been completed in October 2019 and a further audit had been completed in October 2020. In the second cycle the audit showed improvements had been made and the number of prescriptions issued for the hypnotic medicine had reduced by 66%.

At the September 2021 inspection we found:

- Prescribing for urinary tract infections had improved and was now in line with local and national averages.
- Prescribing for hypnotics showed a continued downward trend although still above local and national averages.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	NA
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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 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.	NA
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

Medicines management	Y/N/Partial
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 PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in November 2020 we found:</p> <ul style="list-style-type: none"> • Prescription security had further improved, although staff had not always fully completed the records as intended. • Vaccine fridge temperatures had been measured at outside the recommended temperature ranges and appropriate action had not been taken. • Not all patients diagnosed with a long-term condition or on high risk medicines had received the required monitoring checks or a medication review in the last 12 months. • Other than for high risk medicines, there was a lack of a clear process to ensure patients had received monitoring checks or medicine reviews before a repeat prescription was issued. • The medicine review records did not document any changes or reasons for continuing the medicines. <p>At the September 2021 inspection we found:</p> <ul style="list-style-type: none"> • Records relating to prescription security had improved and were fully completed. • Vaccine fridge temperatures and records were maintained within the recommended range although staff had not always reset the equipment each time as per practice protocol. • The medicine review records were continued to lack detail and did not document any changes or reasons for continuing the medicines. 840, (37%), medicines reviews had been completed in last 3 months. • As part of our inspection, we undertook a remote search of the practice's clinical records system to review the monitoring of patients prescribed high risk medications. Although we found most patients received appropriate reviews for their condition and/or medication, we found several examples where a review had not been completed with the recommended timeframe or that not all the required monitoring checks had been completed or recorded. <p>For example, we reviewed data for medicines used to treat auto-immune conditions – nine patients were prescribed one specific type of this group of medicines. Records for five patients were checked, one patient record had not been kept up to date with the blood results. Evidence was provided after the inspection which showed the appropriate tests had been undertaken. One patient prescribed another type of these medicines had not had their weight recorded although the provider told us this patient was under secondary care for this medicine.</p> <p>We reviewed data for medicines used to treat raised blood pressure and heart failure, 239 patients were prescribed this medicine but 69 had not had the required monitoring checks. We looked at five of these patient records, all were over a year since the blood tests were last completed including two dating back to 2017. Guidance states patients should have their bloods checked at least annually. We observed that the practice had a new IT system in place which had enabled them to identify and notify patients who were due for monitoring checks and of the five records we checked four had been contacted in this respect prior to the inspection.</p> <p>We reviewed data for medicines to reduce the risk of blood clots, 16 patients were prescribed this medicine and five had not had the required blood monitoring checks. We looked at the five patient records and found four were overdue by up to six months and one was just overdue.</p>	

Medicines management	Y/N/Partial
<p>Data showed there were 50 patients who may have chronic kidney disease diagnosis. We looked at five of these patients records and found one who required encoding to ensure reviews continued.</p> <ul style="list-style-type: none"> • Receptionists issued prescriptions, they did not initiate or alter prescriptions, however, our review of management of high-risk drugs indicated that prescriptions were issued without ensuring the required monitoring, including blood tests, had been completed as required. • Defibrillator checks had been completed weekly up to 7 August 2021. Practice policy stated weekly checks to be done. However, evidence showed the practice had not been able to use the equipment since this time as no replacement pads were available from the manufacturers currently. The practice had use of a nearby community defibrillator and a protocol was in place for this. 	

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:	9
Number of events that required action:	9
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Records of significant events showed learning had been identified and there was evidence learning was shared through discussion in meetings and training. 	

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

Event	Specific action taken
Referrals not managed correctly	Following an incident with an urgent referral the practice reviewed its system to ensure all referrals had been completed up to date. They had completed a root cause analysis investigation, discussed the incident in meetings, recruited additional administration staff and provided staff training.

Prescriptions for dispensing trays not managed in a timely manner	Root cause analysis completed, discussed incident and findings in staff meetings, implemented a standard operating procedure and provided staff training.
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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"> A log of alerts and action taken was maintained and alerts were signed as seen by the provider. An additional log of alerts relating to medicines prescribing had been implemented in 2019 which showed actions taken in response to these. Alerts were discussed in meetings and clinicians signed the alerts to indicate they had seen them. Our patient record searches found medicines which were the subject of a safety alert which were still being prescribed together for eight patients. We reviewed five of these patients and found these medicines were still being prescribed and patients had not been informed of the risks. After the inspection the provider provided information that all eight patients had been reviewed and the patients informed of the risks and their prescription had been changed. 	

Effective

Rating: Requires Improvement

We inspected the practice on 9 July 2019 and rated the practice inadequate in effective because the provider could not demonstrate that staff had completed training in required areas and there was no regular schedule of appraisals for staff. Following inspections in December 2019 and February 2020, the practice was rated requires improvement.

At the inspection on 18 November 2020 we rated the service requires improvement for effective services and requires improvement for all population groups. This is because we found that improvements had been made in relation to the previous breaches of regulation, but we also found additional areas of concern. Patients' needs were assessed, but care and treatment was not always delivered in line with current standards and evidence-based guidance in relation to reviews of patients with long term conditions and a learning disability. Some performance data was below local and national averages in relation to care and treatment of patients with long term conditions, cancer screening and childhood immunisations.

At the inspection in September 2021 we rated the practice as requires improvement for effective services and requires improvement in population groups people with long term conditions, families, children and young adults and working age people. Whilst we found diagnosis and monitoring had improved for some groups such as patients with diabetes there was insufficient improvement in other areas.

- Patients' needs were assessed, but care and treatment were still not always delivered in line with current standards and evidence-based guidance in relation to reviews of patients with long term conditions. Not all patients with heart conditions, Chronic Obstructive Pulmonary Disease (COPD) or Asthma had received annual health checks or medicines reviews.
- Some performance data remained below national targets in relation to cancer screening and childhood immunisations.

- Records were inconsistently completed where Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions had been made.

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
Explanation of any answers and additional evidence: There was evidence new guidance and safety information was discussed at clinical meetings. Referral pathways had been reviewed following a significant incident in this area and were monitored to ensure timely referrals were made.	

Older people

Population group rating: Good

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.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice offered structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication 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.
- Twice weekly the chronic and complex care practice nurse provided by the Primary Care Network (PCN) visited frail and housebound patients for health check-ups and medication reviews.
- Home visits were provided by clinical staff where required.
- The practice referred patients for further social care needs assessment where necessary.

People with long-term conditions

Population group rating: Requires Improvement

Findings

At the inspection in November 2020 we rated this population group as requires improvement because we found:

- Not all patients with COPD or asthma had received an annual health review or medicines review and patients with diabetes or heart conditions had not received the required monitoring checks.

At the inspection in September 2021 we rated this population group requires improvement. We found improvements in the management of diabetes. However, patients with heart conditions had not all received monitoring checks and patients with COPD and Asthma had not all received annual health checks or medicines reviews.

- Patients with asthma were offered an asthma management plan. Spirometer testing was offered for COPD and asthma patients although this was curtailed due to covid restrictions. Data for the 12 months up to March 2020 showed the number of reviews undertaken was lower than local and national averages for asthma. (See data table below). We looked at five patient records of those diagnosed with COPD or Asthma who were prescribed inhalers and found some improvement in that all of these had received either a medicines or health review in the last 12 months. However, of these patients, one patient had had an Asthma review, but they had not had a medicines review since 2007 and one had had a medicines review but no asthma review since 2018. The practice told us patients had been reluctant to attend and the availability of clinical staff, who completed the reviews, had also been impacted in recent months.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- We saw improvements in the diagnosis and monitoring of patients with diabetes.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated. However, we found that not all patients prescribed medicines for their heart were monitored appropriately. For example, when we reviewed five patient records for a specific medicine, it had been over a year since the blood tests were last completed including two where the last blood test was in 2017. Guidance states patients should have their bloods checked at least annually.
- 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Near patient testing shared care was provided for patients with arthritis who take immunosuppressive medications.
- Phlebotomy services were available in the practice.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	44.3%	76.7%	76.6%	Significant Variation (negative)
PCA* rate (number of PCAs).	1.3% (2)	3.7%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	95.5%	90.0%	89.4%	No statistical variation
PCA rate (number of PCAs).	2.2% (2)	7.0%	12.7%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	69.2%	80.8%	82.0%	Tending towards variation (negative)
PCA* rate (number of PCAs).	24.6% (17)	4.9%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	51.9%	66.2%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	15.2% (19)	10.8%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	49.8%	70.0%	72.4%	Significant Variation (negative)
PCA rate (number of PCAs).	16.4% (50)	5.7%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	84.6%	92.7%	91.8%	No statistical variation
PCA rate (number of PCAs).	10.3% (3)	4.2%	4.9%	N/A

The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QoF)</small>	41.0%	76.3%	75.9%	Significant Variation (negative)
PCA rate (number of PCAs).	20.0% (25)	6.4%	10.4%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

- This data is pre covid pandemic. The practice told us patients had been reluctant to attend during the pandemic and the availability of clinical staff, who completed the reviews, had also been impacted in recent months.

Families, children and young people

Population group rating: Requires improvement

Findings

At the inspection in November 2020 we rated this population group as requires improvement because we found immunisation rates had been below national targets in 2018/19.

At the inspection in September 2021 we rated this population group requires improvement because although the data had improved for the one-year old child immunisations, uptake had reduced slightly in the other four indicators. This data, however, is for the period up to March 2020.

- The practice had not met the minimum 90% for four of five childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of the five childhood immunisation uptake indicators. However, the numbers of children not receiving their immunisations was very small. For example, of the 18 in the one-year old category one had not had their immunisation, of the 26 two-year olds four had not received their immunisation and of the 26 five-year olds three had not had their immunisation.
- The availability of clinical staff, who completed the immunisations, had been impacted in recent months. They had also recently identified that immunisations had not always been correctly documented when immunisations had been completed impacting on data collection. This had been investigated and addressed.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

- Six to eight-week baby checks were provided with the GP.

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) (01/04/2019 to 31/03/2020) (NHS England)	17	18	94.4%	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) (01/04/2019 to 31/03/2020) (NHS England)	22	26	84.6%	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) (01/04/2019 to 31/03/2020) (NHS England)	22	26	84.6%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	22	26	84.6%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	23	26	88.5%	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

- This data had improved in the one-year immunisation uptake but had reduced slightly in the other four indicators since 2018/19 data.
- The availability of clinical staff, who completed the immunisations, had been impacted in recent months. They had also identified that immunisations had not always been correctly documented when immunisations had been completed impacting on data collection. This had been investigated and addressed.

Working age people (including those recently retired and students) Population group rating: Requires Improvement

Findings

At the inspection in February 2020 and November 2020 we rated this population group as requires improvement as cancer screening attainment rates had remained low although some of this data had not been updated since March 2019.

At the September 2021 inspection we rated this population group requires improvement because cancer screening attainment rates data, which had been refreshed to include some data up to March 2021, remained below CCG and national averages/targets and achievement in some areas had fallen slightly since 2018/19.

At the inspection in 2021 we found:

- Patients cervical cancer screening for the March 2021 data capture was 61.7% compared to 65.8% in 2020 and 70.2% in 2019. This is below the 80% target. The availability of clinical staff, who completed the cervical screening, had been impacted in recent months. The practice had identified those women due for a cervical smear and evidence showed they were contacting them and offering appointments. The practice had a new IT system, and this enabled the practice to more easily notify patients about their screening.
- Reviews of patients within 6 months of a cancer diagnosis was 100%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example, before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice usually hosted a life-style counsellor who had clinics two days per week supporting patients with smoking and obesity. However, the lifestyle counsellor was no longer visiting the practice due to the COVID-19 pandemic, but patients could still be referred to the counsellor for review.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/03/2021) <small>(Public Health England)</small>	61.7%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	45.4%	62.8%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	49.1%	60.1%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months,	100.0%	94.6%	92.7%	N/A

who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) <small>(QoF)</small>				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	37.5%	50.5%	54.2%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. The provider told us that, of the 23 on the register, eight had had annual reviews since April 2021.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances and referred these patients to local support services.
- The practice reviewed young patients at local residential homes.
- The practice offered physical and mental health support for homeless patients.
- The practice provided carer support and referred to external organisations for further support where needed.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- The provider told us they had 14 patients living with Dementia on their register and the practice nurse completed the annual health checks for these patients. The practice told us they had carried out dementia reviews for 4 of the patients on the register this year and nine of the patients were under the care of the local mental health team.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All but three staff had received dementia training.
- Patients with poor mental health, including dementia, were referred to appropriate services.

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Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	83.3%	84.8%	85.4%	No statistical variation
PCA* rate (number of PCAs).	17.2% (5)	8.4%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	72.2%	82.1%	81.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	5.7%	8.0%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	498.1	533.9
Overall QOF score (as a percentage of maximum)	89.1%	95.5%
Overall QOF PCA reporting (all domains)	8.1%	5.9%

	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 provided two audits undertaken since the last inspection in November 2020. A cervical cancer screening audit looking at adequacy of the test completed and outcomes for patients and the reaudit of a medicine used to treat gout.

The second cycle audit for the medicine used to treat gout showed improvements had been made. For example, improvement in monitoring checks had increased by 13% to 82% since November 2020.

The provider told us they now monitored unplanned admissions or readmissions to secondary care.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff told us staffing levels had been low which had impacted on training. They said staffing levels had improved and staff had protected time to complete training. • Three new staff had been employed since our last inspection. They had not completed all their required training since starting at the practice. However, two of these staff had provided certificates to show their training had been completed in their previous employment, on the same online system used by the practice, and this was up to date. The third person had a training plan in place. • Appraisals had been completed; reviews were held for new staff at the end of their probationary periods. • A training matrix and training plan was maintained. We observed that where training was due this had been discussed in staff appraisal and a training plan was in place. • Some staff training had been arranged with the Primary Care Network (PCN) and eLearning was provided. 	

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-centered care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • District nurse hand over forms were used. • 111, out of hours services, district nurses and other allied care professionals had access to patient electronic records through a shared system. 	

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"> • The practice usually hosted a life-style counsellor who had clinics two days per week supporting patients with smoking and obesity, but attendance at the practice had been paused during the pandemic. Referrals for support could still be made to the counsellor. • The practice was working with the PCN to implement a weight management scheme and support for patients with long covid. 	

Consent to care and treatment

The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We looked at five patients records where DNACPR decisions had been made. We observed the GP or the palliative care team had entered information onto the patient records in respect of DNACPR decisions. We found the records were inconsistently completed. For example:</p> <ul style="list-style-type: none"> We found one copy of a DNACPR document in the five patients records we reviewed. Mental capacity was referenced on three of the five records. DNACPR only seen to be encoded on one of the records Recommended summary plan for emergency care and treatment (ReSPECT) form seen in one patient record. 	

Caring

Rating: Requires improvement

At the inspection on 18 November 2020 we rated the service requires improvement for caring services. This was because:

- Data relating to patient satisfaction had deteriorated.
- The provider had not undertaken its own patient satisfaction survey.

At the September 2020 inspection we saw some improvement in that the provider had undertaken a patient satisfaction survey and the results were mostly positive. We rated the service requires improvement for caring services because:

- Most patient experience data had continued to deteriorate since the last inspection.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive variable 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
<p>Explanation of any answers and additional evidence:</p> <p>Training had been given on empathy and cultural awareness.</p>	

National GP 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 (01/01/2021 to 31/03/2021)	64.5%	87.0%	89.4%	Variation (negative)
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 (01/01/2021 to 31/03/2021)	64.1%	87.7%	88.4%	Variation (negative)
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 (01/01/2021 to 31/03/2021)	78.1%	94.7%	95.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	52.6%	83.0%	83.0%	Variation (negative)

Any additional evidence or comments

The patient experience data had continued to deteriorate since March 2019.

Question

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

Y/N

Y

Any additional evidence

At the inspection in November 2020 there was no evidence the practice had completed its own patient surveys to assess the quality of the care provided.

At the September 2021 inspection the practice had undertaken a survey. The practice had sent 150 survey text messages to patients who had had an appointment at the surgery in August 2021, 22 responses had been received. The majority of these were positive. Where patients had commented the

practice had shared this with staff at meetings. However, as the survey responses were anonymous, and some comments were vague, clear learning opportunities were limited.

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: Easy read and pictorial materials were available.	

Source	Feedback
Comments received by CQC - three since the last inspection	Concerns about timeliness of care and prescribing.
Online reviews - two since the last inspection	Concerns about care and treatment and quality of the service.

National GP 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 (01/01/2021 to 31/03/2021)	80.2%	92.2%	92.9%	Tending towards variation (negative)

Any additional evidence or comments

The data about patients being involved in decisions about their care had improved slightly from 78% in March 2020.

	Y/N/Partial
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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: The practice had a multi-lingual GP and receptionist.	

Carers	Narrative
Percentage and number of carers identified.	51 carers identified which is 2.2% of the patient list. No young carers had been identified.
How the practice supported carers (including young carers).	The practice promoted the local carers support group. There was evidence carers were invited for a health check.
How the practice supported recently bereaved patients.	The practice telephoned recently bereaved patients to offer their condolences.

Privacy and dignity

The practice respected respect patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We observed several patients' records had alerts on the home page stating which Doctor they liked to see. • Staff met patients at the car/taxi with a wheelchair if they had mobility issues. • A complex care nurse, twice weekly, visited the housebound, frail and complex patients at home. • Hearing loops were provided. • Interpreter services were available, and the practice had two multilingual staff. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6.30pm
Tuesday	8am - 7pm
Wednesday	8am – 6.30pm
Thursday	8am – 7pm
Friday	8am - 6.30pm
Appointments available:	
Monday	9am – 6.30pm
Tuesday	9am - 7pm
Wednesday	9am - 6.30pm
Thursday	9am - 7pm
Friday	9am – 6.30pm

Older people

Population group rating: Good

Findings

- All 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.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- For children and students, three emergency appointment slots were provided with the GP every day.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open for appointments until 7pm Tuesday, Wednesday and Thursday where patients could book to see a doctor or nurse.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available on Saturday and Sunday 10am until 1pm.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances and those with a learning disability.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Access to the service

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

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritized.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • All requests for appointments were triaged by the GP. The practice had a new IT system and were in the process of implementing online triage using this system. 	

- Doctors, nurse and health care assistant would undertake home visits when required.

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 (01/01/2021 to 31/03/2021)	59.9%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	51.9%	71.6%	70.6%	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 (01/01/2021 to 31/03/2021)	53.3%	67.0%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	76.7%	86.0%	81.7%	No statistical variation

Any additional evidence or comments

Most of these results had improved since the last data collection in March 2020. At the inspection in November 2020 the practice had developed an improvement action plan and told us a new phone system had been implemented and they had employed an additional staff to try to improve access arrangements.

During the pandemic all requests for appointments were triaged by the GP and moves to telephone and video consultations had provided new ways for the patients to access the practice.

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.	4
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Complaint responses were detailed with an apology, an explanation of lessons learnt, and action taken and information on how to escalate the complaint if the person was not happy with the response. Records showed processes and protocols had been changed following complaints and additional staff training had been provided. For example, in the management of repeat prescriptions. Complaints were also recorded and investigated as significant events where relevant. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Unwell patient not correctly assisted by staff	Discussed in staff meeting and protocols reiterated.
Online booking cancelled	Discussed in staff meeting and new protocol in place. New IT system purchased for online triage.

Well-led Rating: Requires Improvement

When we inspected the practice in July 2019, we rated the practice inadequate for providing well led services. Following inspections in December 2019 and February 2020, some improvements were noted, and practice was rated requires improvement.

At the inspection in November 2020 we found improvements had been made to meet the previous breaches of regulation, but we found additional areas of concern related to the management and oversight of the service. We rated the practice requires improvement for well led because:

- There were gaps in systems to assess, monitor and manage risks to patient safety relating to fire safety, legionella and prescribed medicines.
- Patients' needs were assessed, but care and treatment was not always delivered and reviewed in line with current standards.
- Feedback from patients had deteriorated.

When we inspected the practice in September 2021 we found:

- There had been a stable management team since January 2020. Additional clinical and reception staff had been recruited. Staff told us they felt the practice had improved and there were enough staff now after a period of low staffing which had impacted on service delivery and staff ability to complete training.
- There had been improvements in management oversight and improvements in recruitment and health and safety since the last inspection. The environment had been improved following a programme of refurbishment. However, not all the required fire safety and legionella checks had been implemented.
- The practice had implemented new IT systems to assist them further in the improvement of the practice and whilst this was at the early stages of implementation the practice was already using this to improve patient recall for cancer screening and monitoring checks although this had not yet impacted on the data in these areas.

- Whilst there had been some improvements in care and treatment provided compared to the last inspection, such as in the management of diabetes, there were still some areas of concern relating to effective monitoring of patients prescribed high risk drugs or with long term conditions.

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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in November 2020 we found improvements had been made. We identified concerns relating to management and oversight of the service in some areas. For example, health and safety where recommendations and best practice guidance had not always been fully implemented and effective care and treatment in relation to monitoring and review of patients with long term conditions.</p> <p>As part of the September 2021 inspection, with the providers permission, we completed data searches on the patient record system. This enabled us to establish, for example, how high-risk medicines and patients with long term conditions were managed. Whilst there had been some improvements in the searches we completed compared to the last inspection, such as in the management of diabetes, there were still some areas of concern relating to effective monitoring of patients prescribed high risk drugs or with long term conditions.</p> <p>There had been improvements in recruitment and health and safety since the last inspection. The environment had been improved following a programme of refurbishment.</p> <p>There had been a stable management team since January 2020. Additional clinical and reception staff had been recruited. Staff told us they felt the practice had improved and there were enough staff now after a period of low staffing which had impacted on service delivery and staff ability to complete training.</p> <p>The practice had a detailed business continuity plan in place which dealt with the outbreak of a pandemic. Government guidance related to the COVID-19 pandemic had been implemented and discussed in staff meetings.</p> <p>There was evidence regular meetings were held with staff and new guidance, safeguarding alerts, and significant incidents were discussed, and minutes were circulated.</p>	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y

There was a realistic strategy to achieve their priorities.	Y
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:	
<p>At the November 2020 inspection we found: Issues identified in the previous inspections had been addressed. Action plans for improvement were in place and regularly monitored and discussed in meetings with staff. However, whilst we saw improvement new concerns were also identified and some governance arrangements had not been fully embedded into practice.</p> <p>At the September 2021 inspection continued improvement in governance had been made and the practice had implemented new IT systems to assist them further in the improvement of the practice and whilst this at the early stages of implementation the practice was already using this to improve patient recall for cancer screening and monitoring checks.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior 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 candor.	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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	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:	
<p>We saw evidence from records of significant events of action taken manage behavior inconsistent with the vision and values.</p>	

Staff felt there had been improvements and that they were involved. They felt they could raise issues and felt listened to.

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

Source	Feedback
Staff interviews	Staff told us they felt the practice had improved and they were involved. Staffing levels had improved and they felt listened to.

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: At the November 2020 inspection we found: <ul style="list-style-type: none"> Systems and processes had not always been fully implemented as intended and a lack of management monitoring and oversight. At the September 2021 inspection: <ul style="list-style-type: none"> There had been improved management oversight of systems and processes and a more consistent completion of tasks. Staff were clear about their roles and, due to improved staffing, had more time to complete tasks allocated to them. 	

Managing risks, issues and performance

There were some 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.	N
A major incident plan was in place.	Y

Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>At the November 2020 inspection we found:</p> <ul style="list-style-type: none"> • Some areas still required improvement and continued management oversight to ensure processes introduced were maintained as intended by staff responsible for carrying out the tasks. • We found health and safety recommendations and best practice guidance had not always been fully implemented in relation to fire safety checks and management of risks relating to Legionella. • Systems to ensure effective care and treatment in relation to monitoring and review of patients with long term condition's and medication reviews had not been effectively implemented. • Data showed some deterioration in patient satisfaction and an action plan had been developed and implemented but there was no evidence the practice had taken any other action to monitor the effectiveness of their actions such as a patient satisfaction survey. <p>At the September 2021 inspection:</p> <ul style="list-style-type: none"> • We found improvement in health and safety processes and management of some risks. • Management of diabetes had improved but systems to ensure effective care and treatment in relation to monitoring and review of patients with some long-term condition's and high-risk drugs had not always been effectively implemented. 	

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.	NA
Explanation of any answers and additional evidence:	
At the last inspection in November 2020:	

- The practice had developed an improvement action plan and told us a new phone system had been implemented and they had employed an additional staff to try to improve access arrangements.

At the September 2021 inspection:

- Data showed patient experience in relation to access had improved compared to the last data collection in March 2020.
- Additional reception staff and a health care assistant had been employed since the last inspection.
- During the pandemic all requests for appointments were triaged by the GP and moves to telephone and video consultations had provided new ways for the patients to access the practice.
- Clinical staff availability over the last few months had impacted on service delivery in respect of cancer screening and the childhood immunisation programme. The practice were aware of this and were working through any back log. They had implemented new IT systems which were helping to improve patient recall.

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
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

At the inspection in November 2020 we found:

- The practice had addressed most issues identified in previous inspections and had developed and implemented action plans to assist them. However, data showed performance had not improved significantly and some risks relating to medicines management were not always well controlled.

At the September 2021 inspection we found:

- The practice had addressed most issues identified at the last inspection. However, some of the data in this report has not been refreshed since that inspection and therefore the impact of any improvements implemented may not yet be shown. The covid pandemic and clinical staff availability over the last few months had impacted on service delivery in some areas.

- Our clinical searches showed there had been some improvement in management of some areas such as diabetes but also that there were still areas for improvement in care and treatment and medicine management.

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:	
Information was displayed for patients in the waiting room and on the practice website which included Information Commissioner's Office (ICO) information	

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
<p>Explanation of any answers and additional evidence:</p> <p>At the November 2020 inspection we found:</p> <ul style="list-style-type: none"> There was no evidence the practice had actively sought patient feedback to monitor the effectiveness of their actions such as through a patient satisfaction survey. <p>At the September 2021 inspection we found:</p> <ul style="list-style-type: none"> The practice had undertaken a survey. The practice had sent 150 survey text messages to patients who had had an appointment at the surgery in August 2021, 22 responses had been received. The majority of these were positive. Where patients had commented the practice had shared this with staff at meetings. However, as the survey responses were anonymous, and some comments were not clear learning opportunities were limited. The practice was working with its Primary Care Network to develop and implement new services. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Records identified the learning from complaints and significant events and learning had been shared with staff through practice meetings or training events. The practice had recently implemented new IT systems and software to improve patient care. The practice had worked with the local Primary Care Network to provide services for weight management and long covid. 	

Examples of continuous learning and improvement

- Clinical audit had been used to improve some areas of prescribing.
- The results from clinical searches at the last inspection had been used to improve diabetes management.

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.
- **PHE:** Public Health England.
- **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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.