

## Inspection Evidence Table

Doctors Hardy, Hughes, Harvey and Roberts (1-543095784)

Also known as The Hungerford Medical Centre

**Inspection Date: 10 October 2023**

## Overall rating: Good

At our previous inspection 24 August 2022, the practice was rated requires improvement for providing safe, effective and well-led services. The practice was issued with requirement notices for regulation 12; safe care and treatment, 18; staffing and for regulation 17; Good governance. Ratings of good for caring and responsive key questions were continued from the previous inspection in 2016.

This inspection identified that the issues from the previous inspection had been addressed. However, we found ongoing challenges with access to the service.

The practice is therefore now rated good overall. The key questions safe, effective, caring and well-led have been rated good. The rating for the key question responsive is requires improvement.

## Context

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the sixth lowest decile (6 out of 10). The lower the decile, the more deprived the practice population is relative to others. According to the latest available data, the ethnic make-up of the practice area is 95.8% White, 1.7% Asian, 1.4% Mixed, 0.9% Black, 0.2% Other.

The practice had experienced recruitment issues and had filled a range of vacancies in the months prior to the inspection. Additional roles had also been recruited to support clinical and non-clinical teams. Patient and staff feedback with regards issues with access to the service had led to a review and change of the appointment booking system.

# Safe

# Rating: Good

At our inspection in August 2022, we noted gaps in some aspects of the safe key question. For example, recruitment checks were not conducted in accordance with regulations and staff did not always have the information needed to deliver safe care and treatment. This inspection identified action had been taken to address all the areas we identified previously. This key question is now rated good.

## 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
Explanation of any answers and additional evidence:  Safeguarding policies, training and information supported staff to manage any safeguarding concerns. Information was shared appropriately, this included regular discussions during practice meetings and with external teams such as health visiting teams.  At the last inspection we found that DBS checks were not conducted prior to all staff commencing work at the practice. At this inspection we saw that the policy had been updated and that all staff had DBS checks returned prior to employment.	

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.	Partial
Explanation of any answers and additional evidence:  At the last inspection we found that there were some inconsistencies and gaps in recruitment checks.	

At this inspection we reviewed 4 staff personnel files and saw that the required information was obtained upon recruitment for clinical staff. Non-clinical staff had not been asked to provide information regarding immunisations. The provider informed that action would be taken to ensure that vaccination was maintained for all staff when relevant to their role. All other information was documented as required.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: September 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: September 2023 Actions from fire risk assessment were identified and completed.	Y

### Infection prevention and control

**Appropriate standards of cleanliness and hygiene were mostly met, with some action in progress to improve.**

	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: 21 September 2023	
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The most recent infection prevention and control audit conducted showed the practice had attained 89.5% compliance with standards. There was an action plan in place that documented what was being addressed and when this would be completed. An external audit had been booked for additional review of infection prevention and control the week following the inspection.</p> <p>At the last inspection we found some staff had not completed infection prevention and control training. At this inspection we saw that it was a mandatory requirement, and all staff had all completed training to an appropriate level for their role.</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.	Partial
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 last inspection we found there were a number of staff vacancies that impacted on the workload of the team. At this inspection we saw that most roles had been filled, a number of staff had been employed across the clinical and non-clinical teams. Staff feedback was positive about the improvements with workload and the management of staff absences and busy periods.</p> <p>In the event of absence, staff covered from within the team. Holidays were planned and clinical staff covered in their absence by other employed clinicians or locum staff as required.</p> <p>The majority of staff had not completed sepsis training. The provider informed that they would arrange formal training following the inspection. Information was available to support staff with awareness of the signs and protocol to follow. Not all staff had completed basic life support training due to requiring access to face-to-face training sessions however all were booked in for the week following the inspection.</p> <p>Staff knew the processes for managing emergencies. They were able to signpost to urgent and emergency services or get help from clinicians for deteriorating patients.</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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that there was a backlog of clinical correspondence to be actioned. The provider had contracted an external company in addition to the staff employed by the practice to manage the volume of documents requiring review and management. At the time of the inspection, we saw that this backlog had been resolved and the workflow was closely monitored by the provider.</p> <p>The clinical searches identified that care records were managed in a way to protect patients. We found that the documentation of the sample of records we reviewed was of high quality.</p> <p>The provider had a system to ensure the appropriate action had taken place for test results and referrals.</p>	

### Appropriate and safe use of medicines

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

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) (01/07/2022 to 30/06/2023) (NHSBSA)	0.67	0.94	0.91	Tending towards variation (positive)
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). (01/07/2022 to 30/06/2023) (NHSBSA)	5.1%	6.9%	7.8%	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 (01/01/2023 to 30/06/2023) (NHSBSA)	3.86	4.92	5.24	Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	154.9‰	150.0‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.16	0.47	0.54	Variation (positive)

Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	6.3‰	6.8‰	6.8‰	No statistical variation
--	------	------	------	--------------------------

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of effective 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 medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence, including from clinical searches.	
As part of our inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. These searches were visible to the practice. We found that overall, the quality of documentation and monitoring was good however:	

The clinical searches identified a total of 11 patients taking amiodarone which may be used to treat heart rhythm disorders. Of these we identified 7 patients who appeared to be overdue appropriate monitoring. We sampled 5 of these and found that there were problems with the care for 4 patients.

There were 324 patients aged over 70 years who were prescribed NSAID or antiplatelet medicines. Of these, 94 were not prescribed an additional medicine to reduce the risks of complications. We sampled 5 patient records and found that whilst there were no factors identified that would indicate high risk it was recommended that all these patients were reviewed to ensure safe prescribing of medicines.

The provider informed us that action had been taken to address the issues raised from the clinical searches including review of the systems for monitoring.

**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:	14
Number of events that required action:	14
Explanation of any answers and additional evidence:  Staff told us they were encouraged to raise incidents and concerns, knew the processes for how to do this and were well supported when they did. Incidents were recorded, investigated, and responded to with escalation to a significant event where appropriate. Discussion of significant events and incidents including the learning and any action required took place in regular practice meetings.	

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

Event	Specific action taken
Notes regarding patient test results documented in care record inaccurately.	Information gathered to ensure documentation corrected, process changed for receipt of results over the telephone.
Patient given another patient's document as it was accidentally attached.	Patient records for collection were reviewed and a better organised system was put in place. The actions

	taken were shared with the staff team. The issue was reported to the data protection officer.
--	---

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:  There was a procedure for managing safety alerts that involved forwarding the alerts to designated individuals for action. However, findings from the clinical records review indicated that the system in place for maintaining oversight of the actions taken and to ensure all staff were aware of historical alerts required review.	

## Effective

## Rating: Good

At the last inspection in August 2022, we rated the practice as requires improvement for providing effective services because the practice was unable to effectively demonstrate that all staff had the skills, knowledge and experience to carry out their roles. This inspection identified action had been taken to address all the areas we identified previously. This key question is now rated good.

*QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y



Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:  The service used a coding system to indicate when follow up reviews were required for patients with long term conditions and when medication reviews were required.	

## 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.
- Weekly ward rounds were carried out both by telephone and visits to patients living in residential and nursing homes.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check. There was a dedicated nurse who managed the delivery of annual health checks for patients with learning disabilities.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- Contraceptive services, including fitting of coils at convenient times and promotion of sexual health.

## Management of people with long term conditions

### Findings

As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients with long term conditions were checked to ensure the required assessment and reviews were taking place. These searches are visible to the practice. The records we examined provided evidence that overall patients with long term conditions had been monitored and reviewed appropriately.

However, of 365 patients with hypothyroidism we found 30 were overdue monitoring. We sampled 5 of these patients' records and found that 4 required action. The provider informed us that action was taken following the inspection.

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 influenzae 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)	91	94	96.8%	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)	90	100	90.0%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	90	100	90.0%	Met 90% minimum
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)	90	100	90.0%	Met 90% minimum
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)	106	113	93.8%	Met 90% minimum

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

**Any additional evidence or comments**

The service had met the 95% World Health Organisation target for childhood vaccination in 1 of the 5 target areas and was an improvement from the last inspection. They had met the 90% minimum target for the other 4 areas. The provider told us they were taking action to improve uptake by calling families to attend, using the messaging system, reminding opportunistically, and providing information about the benefits of 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)	18.7%	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)	67.1%	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). (3/31/2023 to 3/31/2023) (UKHSA)	65.1%	N/A	80.0%	Below 70% uptake
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)	57.8%	57.3%	54.9%	No statistical variation

**Any additional evidence or comments**

Unvalidated data shared with us by the practice from their clinical system indicated in September 2023 that 61% of patients eligible had been screened for breast cancer in the last 3 years.

The service was below the 80% uptake for cervical screening target. The practice was aware of issues with patients who do not have cervical screening history due to registering from overseas. Initiatives were in place to help increase uptake such as providing information to patients about the benefits of screening, appointments were available with clinicians at a range of times and at short notice.

### Monitoring care and treatment

The practice routinely reviewed the effectiveness and appropriateness of the care provided. However, there was no planned audit programme in place.

	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
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:  The provider did not have a planned audit programme however had completed a range of audits where we saw examples of improvements as a result.  <ul style="list-style-type: none"><li>Lithium Monitoring: This audit indicated that there were some improvements to be made with regards monitoring of patients prescribed lithium (a medicine usually prescribed to treat mood disorders) to ensure all was completed in a timely manner. The outcome was for closer monitoring to ensure compliance.</li><li>Acute kidney injury: Patients identified who were admitted to hospital with acute kidney injury prescribed combinations of drugs that may increase risks were provided with information and guidance.</li></ul> Other audits included: <ul style="list-style-type: none"><li>Drug safety</li><li>Vitamin B12 deficiency</li><li>Infection prevention and control</li></ul>	

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that there were gaps in the management and support arrangements for staff such as, appraisals and induction. This had been addressed and we saw systems were in place to ensure staff had the supervision and support they required for their roles.</p> <p>Staff provided feedback that they were encouraged with development, had time to complete training and were well supported in their roles.</p>	

### 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

### 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice could refer patients to a social prescriber who was employed by the primary care network and based at the practice.</li> </ul>	

- Patients could be referred or self-refer into a local health improvement initiative, including weight management and smoking cessation.
- The practice had equipment located in reception for patients to check their blood pressure and weight. The information was added to patients' clinical records for clinicians to review.
- Information was available about lifestyle choices and health improvement.

**Consent to care and treatment**

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence</p> <p>We looked at 5 patient records. Alerts were on patient records to indicate a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision was in place. We saw that information had been shared with relevant agencies and that details of the decision were recorded and accessible. The form documenting the full detail of the decision was only available on 1 patient record. The provider informed us that these forms were handwritten and always remained with the patient with the key details being documented into the electronic patient record.</p>	

**Caring**

**Rating: Good**

At the last inspection, the rating for the key question caring was good as awarded at the inspection in October 2016. At this inspection we rated the key question of caring as good.

**Kindness, respect and compassion**

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-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:

We reviewed positive feedback from patients about the care received.

Staff we spoke with and who provided feedback demonstrated a patient focussed approach to their work.

We saw positive interactions between staff and patients at the practice during the site visit.

Patient feedback	
Source	Feedback
Feedback directly to CQC	Staff are efficient and helpful.

### 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)	84.0%	88.9%	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)	81.1%	87.7%	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)	88.8%	94.8%	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)	65.9%	76.8%	71.3%	No statistical variation

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

### Any additional evidence

At the time of the inspection the practice had not conducted its own patient survey however had designed a survey to gather feedback and planned to conduct this following the inspection.

The practice asked patients to participate in the NHS Friends and Family test. This indicated that 60% of patients were dissatisfied with the service, however between July and September 2023 there had only been 5 responses. The provider planned to send the link for the survey to all patients who attended for appointments, add to the kiosk in the reception area and add to the website to try to increase the response rate.

### 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

### 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)	91.0%	92.6%	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.	The practice had identified 279 carers on the patient record system. This was approximately 2.6% of the patient population.
How the practice supported carers (including young carers).	Carers were invited for services such as vaccinations where appropriate. Staff signposted to local services to support patients registered as carers. Information for carers was available at the practice.



How the practice supported recently bereaved patients.	Patients who had experienced bereavement were signposted to specialist services for support. A card was sent to the family and a GP called to offer condolences and support.
--	--

### Privacy and dignity

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

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

## Responsive

## Rating: Requires Improvement

At the last inspection in August 2022 the responsive key question was not inspected but the rating of good was carried over from the inspection in October 2016.

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 provider had reviewed the range of appointments available to develop the service in response. Staff had completed care navigation training to effectively signpost patients to appropriate appointments. The online triage system enabled clinicians to review patients' needs and prioritise urgent appointments effectively.

Extended hours appointments were offered for those who required appointments outside of regular practice opening hours. Appointment times were adjusted for patients who required longer, for example those with a learning disability.

Building work was taking place at the time of the inspection to improve the reception area and improve accessibility.

### Practice Opening Times

Day	Time
Opening times:	
Monday	8am – 6:30pm
Tuesday	8am – 6:30pm
Wednesday	7am – 6:30pm
Thursday	8am – 6:30pm
Friday	8am – 6:30pm
Appointments available:	
Monday	8am – 6:30pm
Tuesday	8am - 6:30pm
Wednesday	7am - 6:30pm
Thursday	8am - 6:30pm
Friday	8am - 6:30pm
Pre-bookable appointments were also available to patients at additional locations through the extended hours service. Out of hours services were provided via NHS 111.	

### 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.
- The practice liaised regularly with community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians contacting with concerns about a child were offered a same day appointment when necessary.

- Pre-bookable appointments were available to all patients at additional locations within the area at evenings and weekends provided by the extended hours service.
- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed address such as homeless people.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice population included patients living in local probation hostels and hostels for people seeking asylum. The practice actively engaged with support workers and translation services to support patients receive care and treatment.
- The provider had identified actions to address uptake of cervical screening. This work was in progress however data did not yet show improvement over time.

**Access to the service**

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to 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).	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>Appointments were available following a triage process conducted to navigate patients to the most appropriate clinician or service. A review of the appointment booking system had taken place following staff and patient feedback received with regards to difficulties accessing the service. The provider had identified that there may be risks with patients unable to access urgent appointments. They prioritised changes to ensure those triaged as requiring an appointment on the day or within the following few days of contacting the service had improved access.</p> <p>An online triage form had been implemented. Following completion of the form by the patient, the nursing team assessed information submitted and contacted to book an appropriate appointment. The provider informed us that there had initially been concerns raised by patients about the changes with the system. They had worked to communicate with and support patients with these changes. They had recognised more positive feedback received in the more recent months. Staff told us that they saw that patients with more urgent needs were able to better access appointments following the changes.</p> <p>Feedback provided by patients directly to CQC was mostly negative about access to the service with concerns raised about the digital requirements for initial contact. The provider had fitted a kiosk in the waiting area so that patients who attended the practice could be supported to complete the information with a staff member. The provider told us that patients who telephoned and informed staff that they were unable to complete the</p>	

online form were offered support from staff to talk through the form as they completed or to do this on their behalf. Additional staff had been recruited and a reception supervisor to allow for additional capacity for this support.

The provider recognised that there were ongoing challenges with access to routine appointments. Prior to implementing further changes, they planned to conduct a patient survey to formally gather feedback about access and patient experience to inform further plans.

### 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)	43.4%	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)	39.7%	60.7%	54.4%	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 (01/01/2023 to 30/04/2023)	37.0%	56.0%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	69.5%	76.6%	72.0%	No statistical variation

### Any additional evidence or comments

Patient feedback from the national GP patient survey 2023 indicated lower than average levels of patient satisfaction. We saw that patient satisfaction rates had declined since the previous GP patient surveys. Patients had also contacted CQC to feedback difficulties with accessing the service including the requirements to complete the online form prior to triage.

The provider had reviewed the feedback, devised an action plan and was working with the primary care network to try to improve access to the service. The system for booking appointments had changed to an online triage prior to booking. There were plans to change the telephone systems to support the new approach. Recruitment and review of systems had taken place to increase capacity across the teams to meet the needs of patients.

Although we saw that action had been taken to address the low levels of patient satisfaction we did not see evidence to demonstrate improvement over time.

Source	Feedback
NHS.uk website (formerly NHS Choices)	Feedback from patients was mostly negative about access to the service.

### 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.	39
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Concerns raised about lack of documentation in patient record.	Alert added to patient record to inform all clinicians of treatment plan.

## Well-led

## Rating: Good

At the last inspection in August 2022, we rated the practice as requires improvement for providing well-led services because arrangements were not in place for identifying, recording and managing risks, and there was limited evidence shown to demonstrate the practice used data and information to monitor and improve performance. At this inspection we saw improvements and that these issues had been addressed. The practice is therefore now rated good for providing well led services.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:  There had been changes to the partnership and registered manager status during the years prior to this inspection. The provider was a partnership comprising of 5 partners. A registered manager application was in progress for one of the partners at the time of the inspection.  At the last inspection we found that not all challenges to the service had been identified or fully understood. We saw that action had been taken with regards to the issues with the workflow backlog and that this has been addressed and managed effectively. Staffing issues had also been addressed with recruitment and improvements with induction and training. Feedback from staff working at the practice showed staff telling us about improvements with management and leadership.  The provider was responsive to challenges and concerns presented to the service including any action points identified at the inspection which were addressed at the time.	

### Vision and strategy

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

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

Explanation of any answers and additional evidence:

Staff told us they were aware of the plans for the service and that they had opportunities to provide feedback and ideas which were listened to and actioned when possible by the management team. Regular staff meetings were taking place in addition to a newsletter sent by email where updates and information were shared.

Action plans were in progress to address the improvements identified from patient feedback.

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found that staff satisfaction levels were mixed across staff teams and that leaders were not always aware of staff views. At this inspection staff feedback was positive about the culture of the service and support received from their team and leaders.</p> <p>Staff had participated in resilience training and a reception manager had been recruited to support staff with managing the workload and demands.</p> <p>Staff told us they were aware of the Freedom to Speak Up Guardian and there was information available to support with raising concerns. However, some staff told us they were not clear who this contact was. The provider told us they would update staff with this information following the inspection.</p>	

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

Source	Feedback
Staff interviews and feedback forms	Staff told us that the team worked well together towards ensuring patients received high quality care. They told us they were well supported in their roles and that communication was well managed.

## 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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:  At the last inspection we found inconsistencies with governance arrangements. At this inspection we saw there had been review and improvements with these systems to ensure effective monitoring of clinical and administrative processes that included recruitment, training and induction for staff.  Review of patient and staff feedback, incidents, complaints and audits demonstrated embedded quality improvement processes.  Plans were in place to manage and improve the uptake of childhood immunisations and cervical cancer screening.  Regular meetings took place however not all were formally minuted and shared with staff. Not all meetings followed structured agendas to ensure necessary information was discussed.	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	



At the last inspection we found there were no assurance systems in place to manage risks, issues and performance of administrative processes and this had led to significant issues with a backlog of work. At this inspection we saw that there had been improvements and the backlog had been managed effectively and was being regularly monitored.

Some patients reported difficulty accessing the practices services if they did not have access to digital devices and felt they were at an unfair advantage not having the ability to book appointments online. The provider was aware of this and was monitoring the responses from patients with regards to the change in system and providing support to patients when required. They had plans to review this in more detail by conducting a patient survey prior to any additional changes with the appointment systems.

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
At the last inspection we found that leaders did not have a holistic understanding of performance across the service. At this inspection we saw that the issues had been addressed.	

### 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.	N/A

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
<p>Explanation of any answers and additional evidence:</p> <p>The provider had reviewed patient and staff feedback with regards to access to the service. As a result of this review, they had worked with stakeholders and developed a change to the appointment system. Staff told us this had resulted in positive change for the service with increased capacity for patients who required urgent appointments. Staff told us that there had been a decrease in negative feedback received from patients and an increase in positive comments with regards access. However, we received negative feedback from patients who shared concerns about the online triage system and felt that this was a barrier to accessing an appointment.</p> <p>The provider shared plans for management of routine appointments to try to improve. Prior to implementing further changes, a patient survey was being rolled out to request feedback from patients about their experience with access and of the care received from the service. The provider was also actively encouraging patients to join the patient participation group to help drive communications and information to and from patients. There had been a poor response rate to the NHS friends and family test survey. The link to this survey had been added to the practice website, a kiosk system on site and the provider informed that all patients would be sent this link or given a questionnaire following an appointment to attempt to increase the number of responses.</p>	

### Feedback from Patient Participation Group.

Feedback
<p>We spoke with a representative from the PPG who told us they were still developing the group following the COVID-19 pandemic as they had stopped meeting over this time. They hoped to increase the numbers of members and there was a focus on this at the time of the inspection. The representative informed that they were aware of the challenges at the service and group members raised concerns from patients. The group members had been introduced to new staff members and attended meetings. However, they had not yet conducted other work such as formally gathering patient feedback or sharing information from the provider with patients.</p>

## 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice worked with the other practices in the primary care network and associated practices to develop services and improve outcomes for patients.</p> <p>Plans to further improve the service included ongoing development of roles across the staff groups and review of the needs of the patient population to adjust services accordingly.</p>	

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of 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 those aged 25 to 49, and within 5.5 years for those 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.