

Inspection Evidence Table

Dr Azim Khan

(1-534575840)

Inspection Date: 25 April 2023

Date of data download: 28/03/2023

Overall rating: Requires Improvement.

The practice was previously rated as Inadequate overall in July 2022 and was placed in special measures. Following the inspection, the practice was issued with two warning notices in relation to breaches of regulation 12 (Safe care and treatment) and regulation 17 (Good Governance).

We conducted an announced focussed inspection of the practice in November 2022 to review compliance with warning notices issued following our inspection in July 2022. We found that action had been taken to address the breaches identified in the warning notice and improvements had been made.

We found that:

- The practice provided care in a way that kept patients safe and protected them from avoidable harm.
- The practice had taken reasonable steps to protect patients and others from the risks posed by healthcare associated infections.
- The provider had implemented effective oversight of the systems and processes designed to deliver safe and effective care.

However, further improvements were required and following the inspection we issued a requirement notice in relation to regulation 12 (Safe care and treatment).

We found that:

- Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care.
- We had concerns regarding the potential over prescribing of SABA inhalers.

The inspection was not rated and therefore the ratings remained unchanged.

At this inspection on 23 April 2023 we found improvements had been made, however, further improvements were required in some areas. The location has been rated as Requires Improvement overall.

Safe

Rating: Requires Improvement

At the last inspection in July 2022, we rated the practice as Inadequate for providing safe services because:

- The practice could not provide assurances that they followed recruitment procedures that ensured the suitability of staff to work in a health care setting.
- There was no evidence of staff being vaccinated in line with the UK Health and Security Agency guidance.
- Effective infection and prevention control measures could not be assured.
- There was no system to ensure that in the absence of key members of staff, patient care and treatment was not compromised.
- Temporary staff had not received induction upon commencing work at the practice.
- Not all clinical staff had completed training to help identify and deal with sepsis.
- The practice could not demonstrate the prescribing competence of non-medical prescribers, including clinical pharmacists.
- The process for monitoring patients' health in relation to the use of medicines including high risk medicines had not been effective.

At this inspection, the practice is rated as Required Improvement for delivering Safe care. We found that those areas previously regarded as Inadequate practice were now much improved with some systems and processes in place to improve safety. Further development was required to ensure safety in all areas.

Safety systems and processes

The practice had most 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:	

A comprehensive Safeguarding Policy was in place which included appropriate information, female genital mutilation, modern day slavery, sexual exploitation. The training levels within the Safeguarding Policy did not correlate with the training levels required by the current best practice standards identified in the Intercollegiate Documents. Regardless of this, staff had completed the appropriate level of training required for their role.

Safeguarding meetings took place every 6 weeks with requests for attendance sent to interested parties from other key stake holder organisations. Meeting minutes evidenced appropriate discussion and sharing of information was recorded.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed a random selection of 3 staff files, all of which included the appropriate information and checks as required by guidance and regulations.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment: 12 April 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: December 2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a record of portable appliance testing (PAT) and equipment calibration carried out, next due in November 2023 with an electrical installation test having been completed.</p> <p>A legionella risk assessment carried out in 2016 identified some concerns and actions required to mitigate associated risk to service users but was not comprehensive. Whilst some actions had been identified, completed, and continued at the prescribed timescales, ongoing testing of water temperature within taps had not been identified as a requirement. Following our inspection, we saw evidence that the provider had requested a quote for a new risk assessment to be undertaken.</p> <p>An external company had undertaken testing of the water in March 2023 which was negative for legionella. Whilst this is good practice it does not provide ongoing assurance of the water safety within the practice.</p>	

We saw evidence that monthly water temperature monitoring had been completed from October 2022 to April 2023 for one hot and one cold tap. It was not identified which taps these were, or exactly what days within the month all the checks were carried out. The member of staff identified to carry out the water testing had not received training on managing the risks associated with legionella. Following our inspection, we saw e-mail evidence that appropriate training had been requested for staff carrying out the legionella monitoring.

Fire Marshalls had received training, 2 fire drills had been carried out in the last 12 months with outcomes and actions required recorded in the staff meeting minutes.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: February 2023	Y
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 practice had developed an action plan following the last infection prevention and control audit and we saw evidence that issues identified had been resolved or mitigated. Actions that required building work were identified to be resolved at the next upgrade of the practice facilities. The action plan covered all identified issues but did not have detail included to monitor progress against timescales or an identified responsible person.</p> <p>Cleaning schedules were in place which identified daily, weekly, and monthly required tasks. During our inspection we saw clinical areas were visibly clean and dust free with cleaning checklists completed. We found cobwebs and food residue under a chair in the reception area.</p> <p>During our inspection we identified cleaning time was limited at the practice. Cleaning was carried out by an external contractor on two days a week for two hours on each of the days. At other times practice staff cleaned the surgery. We reviewed cleaning checklists which included general areas to evidence cleaning. Whilst the cleaning schedules had been completed in the period prior to our inspection they had not identified the cobwebs and food residue found in reception. Following our inspection, we were told the provider had increased cleaning hours provided by the contractor.</p> <p>Cleaning materials were appropriately stored in a locked cupboard with control of substances hazardous to health (COSHH) risk assessments in place and accessible.</p> <p>The provider did not have an identified secure area to store clinical waste between regular collections. The provider's service level agreement with the waste collection company scheduled waste to be collected every two weeks directly from the clinical areas. A provision was in place to allow the provider to arrange extra collections if they were identified as needed between the regular collection schedules.</p>	

The provider carried out minor surgical procedures, a surgical procedures policy was in place which included the requirements relating to cleaning, histology, audit and infection prevention and control. An annual audit was undertaken to review practice and identify any concerns. We reviewed the audit findings from April 2023 which reviewed 70 procedures. All data was appropriately recorded, and no post operative infections had been identified or reported. This evidenced an improvement from the previous audit findings and the audit was scheduled to be repeated in 12 months.

Risks to patients

There were gaps in 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.	Partial															
There was an effective induction system for temporary staff tailored to their role.	Y															
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y															
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y															
There were enough staff to provide appointments and prevent staff from working excessive hours.	N															
Explanation of any answers and additional evidence:																
At our inspection in November the provider had introduced processes to manage planned absence in a safer way which was now embedded within the practice. This did not always provide extra staff with suitable qualifications or training to cover all absences. For example, a registered nurse (RN) was not available to cover when the practice nurse was absent, this meant patient care given was not delivered to the expected standard and a return visit for patients may be required.																
Latest data, updated every 3 months available from NHS Digital shows the ratio of patients to whole time equivalent (WTE) permanent staff was high within the practice when compared to the national average, regular locum GPs were utilised by the practice to improve the ratio but are not included in our data:																
<table><tr><th>Staff Group</th><th>Patients per WTE</th><th>National Average patients per WTE</th></tr><tr><td>GPs excluding locums and registrars</td><td>3310</td><td>1719</td></tr><tr><td>Nurses</td><td>5594</td><td>3082</td></tr><tr><td>Direct Patient Care Staff</td><td>7051</td><td>3884</td></tr><tr><td>Admin and non-clinical</td><td>1267</td><td>850</td></tr></table>		Staff Group	Patients per WTE	National Average patients per WTE	GPs excluding locums and registrars	3310	1719	Nurses	5594	3082	Direct Patient Care Staff	7051	3884	Admin and non-clinical	1267	850
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Staff told us during this inspection that there were still not enough staff to provide all aspects of the care required. The provider told us recruitment had been difficult and was ongoing. We saw evidence that the adverts were in place to recruit more nursing staff and GPs.

Audits were being carried out monthly to assess the increase in telephone contacts. The audits had shown an increase from 1117 contacts in August 2022 to 2551 in March 2023. It was planned to review the audit findings and assess any requirements for an increase in administration and reception staff to manage the increased demand.

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>Review of patient records in relation to the clinical searches identified that care records were written in a way to protect patients and ensure safe continuing care. For example, history, examination, management plans, safety netting, follow up, discussions with patients and, when appropriate family, were adequately documented within the patient record.</p> <p>At this inspection we saw the paper records were stored behind a locked reception door with a risk assessment in place to manage and mitigate foreseeable risks. The provider had applied to be considered for prioritisation in the programme led by the Integrated Care Board (ICB) to digitalise their paper records.</p> <p>There was a process in place for the management of test results, and this was managed in a timely manner. Results were shared and reviewed by another doctor when any absences occurred. On the day of our inspection a review of the clinical system showed there were no results awaiting review.</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) (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	0.81	0.86	0.86	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). (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	5.7%	7.5%	8.1%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	5.30	4.60	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	85.6‰	131.9‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	0.46	0.48	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	3.9‰	6.2‰	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).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of 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 high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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
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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The anaphylaxis kit kept in the medicine cupboard included syringes that had passed the expiry date. This would increase the risk of infection if used on a patient.</p> <p>Clinical searches identified 573 patients coded as having had medicine review in last 3 months. Medicine reviews were coded for some patients despite them not being prescribed regular medicines. Reviews were being undertaken by a variety of clinical staff and not all information was clear in patients notes. For example, medical records were not clear in relation to discussions being undertaken relating to risks of medicine for pain relief.</p> <p>Clinical searches identified 27 patients had been prescribed potentially addictive drugs up to 12 times as repeat prescriptions in the previous 12 months. We reviewed 5 records and appropriate discussion relating to the risks of the medicines was documented in all cases.</p> <p>The provider was able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required.</p> <p>All patients prescribed a medicine to manage an overactive immune system had received appropriate health monitoring in line with national guidance.</p> <p>Clinical searches found 448 patients were taking medicines for high blood pressure. Of those 20 patients had not had the required monitoring. We reviewed 5 of the 20 records and found the provider had attempted to contact patients on numerous occasions using various mediums to attend the practice, furthermore evidence was recorded that medicine had been reduced to mitigate risks of side effect due to patients' failure to attend.</p>	

An alert was placed on a patient's record to identify a review was overdue to ensure this was discussed at next patient contact.

During our inspection we reviewed a sample of 8 Patient Group Directives (PGD) and found 3 of them were either out of date or had not been dated by the responsible clinician or the nurse using the PGD.

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.	Partial
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 since July 2022:	4
Number of events that required action:	4
Explanation of any answers and additional evidence:	

Staff told us they knew how to report significant events raise concerns and incidents. They were aware of significant events and complaints reported and told us of changes made to practices in light of investigation findings.

During our inspection we identified an issue that should have been reported as an incident, but staff had not recognised this. Following our inspection, we received information that accident and incident reporting had been discussed in the April staff meeting and had now been added as a standing agenda item to all meetings.

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

Event	Specific action taken
Cervical smears unable to be conducted due to login issues with the NHS data system.	All patients due cervical screening were informed and re booked. Password holders at the practice increased to aid any password resets to help with preventing a reoccurrence. Patients informed throughout.
Childhood immunisations administered outside guidance.	Reported to Screening and Immunisation Team IT. Further education and training delivered to reception and clinical staff. No action was required to readminister vaccines. Parents kept informed
A red flag task was closed by staff before it was resolved leading to a delay in diagnosis.	Changes to the system of dealing with an urgent task – never now closed unless there is a documented end to the event. Apology given to patient.

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
We saw examples of appropriate actions taken on recent alerts, for example, regarding sodium valproate and medicine for diabetes.	

Effective

Rating: Good

At the last inspection in July 2022, we rated the practice as Inadequate for providing effective services because:

- Not all patients with long term conditions or potential long-term conditions had received up to date monitoring and review.
- Not all staff had completed training essential to their role.
- Staff had not received an induction when first employed by the practice.

At this inspection, the practice is rated as Good for delivering Effective services. We found that those areas previously regarded as Inadequate practice were now much improved with systems and processes embedded within the practice to maintain improvements to deliver effective care.

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 were 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
Clinical searches undertaken identified a good recall system in use within the practice to ensure patients' ongoing needs were fully assessed with regular reviews and updated treatments taking place.	
The practice had prioritised care for their patients during the pandemic and had continued delivering some face to face appointments throughout that time.	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.
- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- All patients with a mental health concern were offered an annual health check.
- The clinical searches identified 13 patients with a high blood sugar that were at risk of damage to their eyesight. We reviewed 5 records, of which 1 was not reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. Following our inspection, we saw evidence that the patient had been reviewed by the provider and action taken to update the patient's treatment.
- The clinical searches identified 16 patients who required 2 or more high dose steroid treatments for severe asthma episodes in the previous 12 months. We reviewed 5 records, all of which were followed up in line with national guidance to ensure they received the appropriate care.

Management of people with long term conditions

Findings

- Clinical searches showed that all patients at risk of diabetes had been identified appropriately and health reviews undertaken in line with best practice.
- 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 GPs worked with other health and care professionals to deliver a coordinated package of care.
- Patients with multiple conditions were offered longer appointments to capture all missing actions in one visit.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training that ensured appropriate care was delivered.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	32	33	97.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	37	42	88.1%	Below 90% minimum

Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	37	42	88.1%	Below 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)	37	42	88.1%	Below 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)	29	37	78.4%	Below 80% uptake

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 provider contacted the parents or guardians of children who had not received immunisations in line with the agreed schedule to encourage uptake. Conversations with parents were documented and alerts were on the clinical system for staff to discuss immunisation at the next contact. A letter was sent to parents which included written information relating to the vaccination program.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	70.0%	67.7%	66.8%	N/A
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	28.9%	64.5%	61.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	46.9%	55.2%	54.9%	No statistical variation
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). (30/09/2022 to 30/09/2022) (UKHSA)	73.1%	N/A	80.0%	Below 80% target

Any additional evidence or comments

If a patient did not attend for a cervical screening appointment, then a note would be placed on their record to request they rebook at next contact. If a patient had a history of abnormal results, they would be sent a text or telephoned. Evening clinics were in place to allow increased access to cervical cancer screening for women with difficulty accessing appointments in routine hours.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: A clinical audit schedule was in place which included scheduled audits for a range of clinical areas, patient records and medicine. Actions required were identified and evidence of changes included in the audit findings. The provider has a range of reports scheduled to run on a monthly basis to identify patients who required a review if living with identified long term conditions. This proactive measure ensured treatment was optimised and improved as required in a timely way.	

Effective staffing

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

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

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff had access to regular appraisals, one to ones, and revalidation. The introduction of clinical supervision for registered nurses was being reviewed within the Primary Care Network but had not been implemented at the time of our inspection.</p> <p>The provider had a Clinical Audit Policy in place which included regular audits of a pre-determined number of random consultations undertaken by all clinical staff. Findings were shared with staff and any actions required taken to improve clinical knowledge and patient care.</p>	

Coordinating care and treatment

Staff worked work 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
External key stakeholders involved in a patient's care could access the providers clinical system to make appointments, see patient care records and test results to ensure consistent and co-ordinated care was maintained.	

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> <p>The provider had an identified palliative care lead who had overall responsibility for the patients receiving end of life care. Meetings took place every 3 months with representatives from all professions involved in the care from both within the practice and those employed by other agencies. Any concerns arising between the meetings were raised with the appropriate clinician on an as required basis.</p>	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence.</p> <p>Our clinical review of notes where a DNACPR decision had been recorded identified where possible the patients' views had been sought and respected. We saw that information had been shared with relevant agencies and evidence of a multi-disciplinary review.</p>	

Responsive

Rating: Good

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive from 2016 inspection at this time. Responsive remains rated as good.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	

The provider had identified the specific requirements of the local population. Information was available on the practice website advising available options for individual specific needs. This included information relating to the availability of chaperones, choice of a GP's gender, ability to bring a friend, information for carers and an interactive website for children aged between 5 and 11 years of age which provided age appropriate health information in a child-friendly format.

The provider made reasonable adjustments for patients with individual specific needs. The surgery was accessible for people with mobility issues, a hearing loop and large print communications were available to assist patients with hearing and visual difficulties and interpreting facilities including British sign language could be booked in advance.

Practice Opening Times		
Day	Time	
Opening times:		
Monday	8am - 8pm	
Tuesday	8am - 8.30pm	
Wednesday	8am - 6.30pm	
Thursday	8am - 6.30pm	
Friday	8am - 8pm	
Appointments available:		
Monday	8am - 11am	4pm – 8pm
Tuesday	8am - 1pm	2pm – 8.30pm
Wednesday	8am - 1pm	2pm – 5.30pm
Thursday	8am - 1pm	2pm – 5.30pm
Friday	8am - 11am	4pm – 8pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> • 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 the community services to discuss and manage the needs of patients with complex medical issues. • Additional nurse appointments were available 3 evenings a week, so school age children did not need to miss school. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. • Pre-bookable appointments were also available on evenings and weekends to all patients at additional locations within the area, as the practice was a member of a Primary Care Network (PCN). • Extra clinics were in place to allow increased access to cervical cancer screening and vaccination to improve access.

- 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 abode such as homeless people and travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

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.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <p>Routine GP and nurse appointments could be booked online, by telephone and in person at the practice.</p> <p>Enhanced Access was also available Monday to Friday from 6.30pm-8pm, weekends and bank holidays from other practices within the PCN.</p> <p>Appointments were released each day at two specific times, in the morning and afternoon for later appointments. We saw evidence that the GPs regularly worked in a flexible way and extended clinic sessions to ensure all patients needing a face to face GP appointment were seen.</p> <p>The provider had undertaken a digital roadshow with support from the Integrated Care Board (ICB) to promote the use of the NHS App and booking of appointments using texts. This would allow easier access for patients and minimise wait times. Plans were in place to repeat the roadshow in coming months.</p>	

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 (01/01/2022 to 30/04/2022)	86.8%	N/A	52.7%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	78.8%	59.5%	56.2%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	71.4%	58.5%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	82.4%	74.5%	71.9%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	Since our inspection in October 2020, 3 reviews had been posted on NHS.uk website. All 3 rated the provider as 5 star and were overwhelmingly positive. Comments were from patients who had been registered with the provider for some time. The comments included positive remarks for staff's caring attitude and willingness to go the extra mile.
Comments and letters received by the practice reviewed on the day of inspection	We reviewed 8 randomly selected comments on site during our inspection. All were positive about staff attitude, access to appointments and care received.

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.	Four
Number of complaints we examined.	Four

Number of complaints we examined that were satisfactorily handled in a timely way.	Four
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

Example(s) of learning from complaints.

Complaint	Specific action taken
Inappropriate discussion relating to completion of a ReSPECT form.	Discussed with individual clinician and apology given to patient and family. Changes made to how ReSPECT forms are managed within the practice
Staff attitude to people who had attended the practice when Covid positive.	Changes to communication given to people on attending surgery if positive for Covid.

Well-led

Rating: Requires Improvement.

At the last inspection in July 2022, we rated the practice as Inadequate for providing Well-led services because:

- The provider did not have clear oversight of the systems and processes required for the safe and effective delivery of the regulated activities.
- Effective practice management was hampered through lack of experience and knowledge of systems and process and time constraints.
- Patient records held in paper format were not stored securely to ensure their protection from loss or damage.

At this inspection, we found that areas previously regarded as Inadequate practice were now improved and some systems and processes were in place but were not effective in all areas.

At this inspection, the practice is rated as Requires Improvement:

- The provider had developed a greater oversight of the systems and processes required for the safe and effective delivery of the regulated activities; however further improvements were required.

Leadership capacity and capability

Leaders were able to demonstrate that they had the capacity to deliver high quality. The skills to deliver high quality and sustainable care had improved.

	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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Leaders within the practice were responsive when challenges to quality and sustainability were identified, and swift action was taken to resolve or mitigate issues and risks. For example, our clinical searches highlighted an issue with the coding of medicine reviews. It was identified that some patients had been coded as receiving a medicine review despite the fact that they did not receive regular repeat prescriptions. Actions were put in place following our inspection to review and resolve these issues.</p> <p>Support for the practice manager to continue to develop their skills and knowledge had been implemented and was ongoing. This utilised both a workforce development programme supported by the Local Medical Committee (LMC) and from within the practices within the Primary Care Network (PCN). Included was a dedicated experienced roving practice manager who attended the practice to support on a one to one basis and regular PCN meetings with the other experienced practice managers.</p> <p>Since our previous inspections, the practice manager had increased their hours and an assistant practice manager had been appointed who was undergoing training. Difficulty in recruiting permanent doctors to the practice, with a view to becoming partners had been identified in our previous inspection and this continued. Recruitment was ongoing with adverts currently in place. If successful, this will lead to the development of further succession plans.</p>	

Vision and strategy

The practice had a vision, and it was supported by credible plans 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.	Partial
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p>	

At this inspection 8 staff provided feedback of which 4 stated there was either no vision or it was unclear. None of the 8 said they had been involved in developing the strategic planning (mission statement, vision, or values) of the practice. Since we received the feedback, we have seen evidence that staff were requested to provide comments and suggestions to develop the vision further during a team meeting.

The provider had credible plans to support the vision to provide high quality care and the management team regularly reviewed these.

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 inspection in November 2022 a process had been introduced to manage staff. An absence policy was put in place that related to the management of planned absence and gave guidance on the numbers of staff that would be allowed leave at any one time.</p> <p>At this inspection we saw evidence all staff had completed equality and diversity training.</p> <p>A Whistle Blowing policy was in place which identified both internal staff and an external individual as Freedom to Speak up Guardians. Contact details were included for both, and staff told us they were aware of the process to raise concerns.</p>	

Source	Feedback
Staff	Staff feel very supported by colleagues who are described as helpful with high levels of patient care. It is described as an inclusive, learning environment the atmosphere is usually good. It is busy and can get stressful and feedback from some groups indicated more staff would help.

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had systems in place to ensure all staff, including staff employed by other parties who delivered care to the provider's patients were clear on their roles and responsibilities.</p> <p>Communication was effective and organised through structured, minuted meetings attended by all staff.</p> <p>All clinicians met regularly to discuss work prioritisation and vulnerable patients as well as difficult cases and current events.</p> <p>There was a good relationship with community teams to ensure patients received effective coordinated care.</p>	

Managing risks, issues and performance

There were not always clear and effective processes for managing all risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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 this inspection we found concerns related to the oversight of risks identified in previous inspections had improved. The provider had implemented processes that included audits, training compliance monitoring, risk assessments, changes in recruitment practice and monitoring of staff competence and safety of care.

However, the systems and processes in place were did not cover all aspects of risk reviewed during our inspection. This included management of legionella risks, providing appropriate registered nurse cover when the practice nurse was absent, cleanliness and oversight of patient group directives.

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice used clinical data to drive performance and demonstrate improved outcomes for patients. The automated searches in place to review patients with long term conditions provided appropriate data to improve performance, manage patients' long-term conditions and improve outcomes.</p> <p>Review of data relating to the increase in activity and contacts made to the practice was being used to review and potentially increase staffing levels.</p>	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y

Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	NA

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>During our inspection in April 2023, we reviewed an Engagement Access Plan from July 2022, which was developed by the Primary Care Network (PCN) following a patient survey which covered all practices within the network. The plan was used to improve the services at the practice to reflect the needs of the population.</p> <p>A patient survey conducted in July 2022 had sought patients' views on the type of appointment they would want available during extended access surgeries. This had been used to develop clinical sessions to meet patient need.</p> <p>The Patient Participation Group (PPG) had recently been re-introduced and had increased membership with meetings undertaken every 2-3 months. The PPG had developed a staff wellbeing garden at the practice to give staff a relaxing and pleasant area to spend time in for breaks and time out.</p> <p>We saw a formal meeting schedule was now in place for regular meetings for all staff groups. Meeting minutes provided evidenced these had taken place and staff views on the visions, values and future of the service were discussed and taken into account.</p>	

Feedback from Patient Participation Group.

Feedback
<p>We spoke to two members of the PPG during our inspection. They told us the provider was responsive to feedback from the group and made changes to services if appropriate. Staff were described as helpful and friendly, and they reported access to appointments was never an issue.</p>

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>The provider had implemented many changes in systems and processes to improve the quality and safety of care since the Care Quality Commission's inspections in July and November 2022.</p> <p>An effective process was in place to ensure all staff were up to date with the practice's mandatory training. Staff told us they were given the opportunity to develop and learn. The provider had not introduced training on autism and learning difficulties. It was identified in the Health and Care Act 2022 that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role.</p> <p>Continuous monitoring of training and development was carried out by the management team and learning from events, complaints and compliments was shared to enable lessons to be learnt and improvements to services were acted on.</p> <p>The leadership team organised monthly protected learning time for clinical staff to ensure essential training was updated and completed accordingly.</p>	

Examples of continuous learning and improvement

The practice had applied for and been accepted to be part of a pilot to digitalise patient records and were awaiting the start of the process which had been put on hold due to the Covid Pandemic. Due to concerns relating to paper held records, the provider had requested to be prioritised within this process.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

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

Glossary of terms used in the data.

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