

## Inspection Evidence Table

Dr I P Tolley and Partners

(1-547667801)

Inspection Date: 19 April 2023

Date of data download: 04/04/2023

**Overall rating: Good**

**Safe**

**Rating: 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

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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	P <sup>1</sup>
Date of last assessment: Various dates	Y
There was a fire procedure.	Y
Date of fire risk assessment: May 2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1. We found the practice had a system to manage risk assessments, however we found that the management of legionella (a bacteria which can cause legionella disease) was not robust. The practice had annual water samples undertaken (last one March 2023, which showed that no legionella was present) however, they did not undertake regular checks of the water temperatures to monitor and mitigate any risks. The practice took immediate action, implemented a system and sent us evidence of the temperatures recorded.</p>	

### Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 20 July 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a wheelchair available for any patient who required it. We noted this was clean and in good repair but that it did not appear on the Infection Prevention and Control audit (IPC) audit. We discussed this with the practice who added this to their routine cleaning schedules and policy. The practice was aware of areas which needed to be refurbished, such as some clinical rooms which had carpeted flooring. These rooms had been risk assessed and only appropriate consultations took place. The practice had quotes for new flooring and had a plan for these rooms to have new hard flooring laid.</p>	

## Risks to patients

**There were adequate systems to assess, monitor and manage risks to patient safety.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y

## 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.	P <sup>1</sup>
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y <sup>2</sup>
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>1. We found in most cases that medical records were of a standard that met the requirements including those where a medicines review had been coded. However, we also found that some patient records did not evidence discussion of risks in relation to medicines.</p> <p>2. The practice used electronic transfer of medical records but due to staff shortages, a backlog of summaries had developed. New staff had been employed and the backlog had consequently reduced. For example, in March 2023 there were 239 notes to be fully summarised, in April 2023 this had reduced to 201. The practice used electronic transfer of records and the practice stored the files so that clinical staff had easy access to them should they require it.</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) (NHSBSA)	0.86	0.97	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) (NHSBSA)	11.4%	10.1%	8.1%	Tending towards variation (negative)
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) (NHSBSA)	6.53	5.74	5.24	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	89.4‰	197.7‰	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) (NHSBSA)	0.55	0.90	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	6.9‰	12.0‰	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.	P <sup>1</sup>
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 <sup>2</sup>
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
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.	P <sup>3</sup>
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>1. The practice could not fully demonstrate the prescribing competence of non-medical prescribers, as there was no process in place to formally document the supervision given for reflective learning. Leaders told us (confirmed by staff) that protected time was given after each session for the non-medical prescriber to meet with one of the GP trainers (who was not the duty doctor) to go through the patients seen. The staff members told us they documented this for their own learning and appraisal, but this was not recorded by the practice. Reviews of the prescribing of antibiotics for all clinic staff were undertaken to monitor and ensure safe prescribing. Feedback was given to individual clinicians.</p> <p>2. 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. From our clinical searches we identified</p> <ul style="list-style-type: none"> <li>• 70 patients were prescribed methotrexate (a medicine used to treat autoimmune conditions) and all had received the appropriate monitoring.</li> <li>• 17 patients were prescribed azathioprine (a medicine used to treat autoimmune conditions) and all had received appropriate monitoring.</li> <li>• 8 patients were prescribed lithium (a medicine used to stabilise mood) and all had received appropriate monitoring.</li> <li>• 273 patients were prescribed a direct oral anticoagulant drug (DOAC). Of these we identified 2 who had not received the appropriate monitoring. We noted one patient had an appointment booked. The practice told us they would contact the other patient immediately.</li> </ul> <p>3. The practice had all the equipment necessary to deal with a medical emergency. However, the system used to ensure all medicines were easily available was not in place. The practice had not risk assessed which medicines they needed to hold and those that they had were not stored in a manner that would enable easy and swift access in the event of medical emergency. The practice took immediate action</p>	

and ordered the missing item. The equipment, oxygen and medicines available where all regularly checked and in date.

**Track record on safety and lessons learned and improvements made.**

**The practice learned and made improvements when things went wrong although the sharing of outcomes and learning did not include a whole team approach.**

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 <sup>1</sup>
Number of events recorded in last 12 months:	5
Number of events that required action:	5
Explanation of any answers and additional evidence: 1. The practice had written records of significant events that had been reported or that had been identified through complaints they had investigated. We found the events had been discussed with individuals, the GPs, team meetings and patients if appropriate. The outcomes and learning were available for all staff on the practice intranet. However, the practice did not hold regular whole team meetings to discuss these for joint learning and discussions. The practice explained these had not been possible during the COVID-19 pandemic but told us they would be planning to hold these in the future.	

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

Event	Specific action taken
Task had been sent to a diabetic specialist nurse requesting some medicine to be prescribed. The nurse was on leave and the patient experienced a delay in getting their medicine.	The practice team involved discussed the event and the learning from it. This included a review of tasks that had not been actioned and to be aware of staff who may not be in the practice for an extended length of time. A letter of apology was sent to the patient.
Aggressive patient behaviour.	This was discussed with the GPs to review the incident and any triggers. The patient was sent a letter outlining further action the practice may take if the behaviour is

	repeated. The practice put precautions in place to ensure staff safety.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	P <sup>1</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1. The practice had a system to manage and monitor safety alerts. The practice received the alert and cascaded to the clinical GPs. The staff undertook any clinical searches where patients may be at risk and the GPs were responsible for taking action on the relevant alert. The practice stored an electronic copy and also printed a hard copy of alerts and annotated with the date cascaded and actions taken.</p> <p>Using our clinical searches, we looked at the actions the practice had taken in relation to an alert in respect of Febuxostat (a medicine that can be used for the long-term treatment of gout). However, we were not wholly assured that the process for this was safe and effective. Our search identified 3 patients who had been prescribed Febuxostat. We reviewed the medical records of these patients and although the patients had been reviewed regularly, we did not see documented evidence that the risks associated with the medicine had been discussed with the patients. The patients were not overdue medicines review and the practice told us they were confident the discussion had taken place but not documented. We did not identify concerns with other two alerts we reviewed.</p>	

## Effective

## Rating: 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.	P <sup>1</sup>

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.	P <sup>2</sup>
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
<p>Explanation of any answers and additional evidence:  1&amp;2 We found the practice had systems and processes in place that ensured patient monitoring and medicine reviews were appropriately managed such as high risk medicines, and some long term conditions such as patients with hypothyroidism and patient with chronic kidney disease stages 4 or 5. However, we found some patients with long term conditions such as diabetes or asthma had not always received the appropriate follow up care in the appropriate timeframe. The practice was aware of the backlog that had developed during the COVID-19 pandemic and staff shortages and had an action plan to which they were working. They were confident they would be up to date by the end of this year.</p>	

## 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.
- 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. From April 2022 to December 2022 the practice had completed 528 NHS health checks.
- All patients with a learning disability were offered an annual health check. The practice held a register of 52 patients with a learning disability. There was a lead nurse for providing annual reviews for these patients and in the past 12 months, 83% of patients with a learning disability had received a review. The practice worked closely with the local community team to ensure those who had not attended were followed up appropriately. The practice offered appointments at times best suited to the patient and their carer.
- 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. The practice was able to refer to the local Admiral nurses for additional support.

## Management of people with long term conditions

### Findings

- 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 had not always followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma in the appropriate timeframe. Through our clinical searches we identified 55 patients who had been prescribed 2 or more courses of rescue steroids (a short course of steroids and antibiotics issued in advance). We looked at 3 records and found none had received a follow up within an appropriate timeframe and 2 of the 3 patients required a steroid card which had not been issued. The medical records of 1 patient did not contain sufficient documentation of clinical factors to ensure that all factors were considered for safe decision making and the patient had been made aware of any actions to take should their condition deteriorate. Immediately following the inspection the practice shared evidence all these patients had been reviewed and appropriate actions taken.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. However, we found the practice system and process to identify and manage patients with a potential missed diagnosis of diabetes had not been wholly effective. Our clinical search identified 34 patients with a potential missed diagnosis of diabetes. We reviewed 5 of these records and found 4 of the 5 patients had been followed up but not within the appropriate timeframe. We found that some of the clinical coding was not consistent and therefore did not ensure easy and appropriate oversight and recall of patients. Immediately following the inspection the practice shared evidence all these patients had been reviewed and appropriate actions taken.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

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)	77	77	100.0%	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)	80	83	96.4%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	82	83	98.8%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and	82	83	98.8%	Met 95% WHO based target

rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
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)	109	114	95.6%	Met 95% WHO based target

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

Any additional evidence or comments
The practice team including the nurses had a clear process to ensure children were brought for their immunisation appointments. Nurses and GPs were easily available to give advice should this be requested by the parent/guardian.

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)	73.7%	70.4%	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)	75.0%	70.2%	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)	55.7%	54.4%	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)	80.4%	N/A	80.0%	Met 80% target

Any additional evidence or comments
The practice team, including the nurses, had a clear process in place to ensure patients could make and attend their appointments for the screening programme. Nurses and GPs were easily available to give advice should the patients requested it, including for bowel and breast cancer screening.

### 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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice used audits to monitor and manage performance. The practice was a training practice and involved GP registrars in the quality improvement programme.</p> <p>For example, an audit to monitor the service delivered to patients with a learning disability. The first audit (undertaken in August 2021) showed the practice had a register of 81 patients and in January 2022 there were 78 patients with a learning disability.</p> <ul style="list-style-type: none"> <li>• Number of patients who had an annual review. 81% in Aug 2021 and 56% in January 2022.</li> <li>• Number of patients who required cervical screening 38% in August 2021 and 48% in January 2022 (including those who had a signed disclaimer to accept a screening).</li> <li>• Percentage of patients who had received an annual flu vaccination 90% in August 2021 and 85% in January 2022.</li> <li>• Number of patients whose records had recorded that they required reasonable adjustments to access healthcare 2% in August 2021 and 25% in January 2022.</li> </ul> <p>The practice reflected that the challenges of delivering the services to this group of patients during this time was challenged due to the restrictions of the COVID-19 pandemic but told us they were committed to using the data to be fully aware of the areas to focus on and address. Current data showed, the register had 52 patients with a learning disability and 83% of these patients had received a review.</p> <p>Other audits undertaken included those for the national screening programmes for cervical, bowel and breast cancer. Audits were regularly undertaken to review the prescribing of medicines such as antibiotics.</p>	

### Effective staffing

**The practice was able 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

**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

**Any additional evidence or comments**

The practice worked with a social prescriber who was able to see or speak with patients to ensure they were directed to additional services that were available. For example, smoking cessation and weight management services.

**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 <sup>1</sup>
<p>Explanation of any answers and additional evidence.</p> <p>1 As part of our inspection, we reviewed the documentation available in the medical records of 3 patients and found clear documentation relating to the capacity of patients to make decisions, choices, and discussions with relatives and care home staff.</p>	

**Caring**

**Rating: Good**

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion. Feedback from patients was mixed 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

Patient feedback	
Source	Feedback
CQC - Share my care.	We received feedback from patients with the majority of comments being positive about the care and kindness shown by practice staff. We did receive some feedback relating to communication between staff and patients of which the practice was already aware. The practice had a process where staff were supported to use feedback as reflective learning in their appraisals and to look at ways to change their style as necessary.
NHS.uk website (formerly NHS choices)	

	There were 3 comments on NHS choices. Two of these comments were positive about the practice and 1 was negative. The negative comment was in relation to communication for patients no longer in the practice area.
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### 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 (01/01/2022 to 30/04/2022)	79.4%	86.4%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	78.9%	85.8%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	98.3%	94.5%	93.1%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	74.6%	75.7%	72.4%	No statistical variation

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

### Any additional evidence

The practice had not undertaken a survey recently to gather patient's feedback. However, they used information received from patients through complaints and compliments. They reviewed the data from the national GP patient survey to ensure feedback remained positive. Where concerns were identified, patients were given a full response and if changes were required, these were implemented. In August 2022, HealthWatch Norfolk visited the practice, spoke with patients and produced a report with the findings. This confirmed that overall, patients they spoke with were happy with the practice and staff. It reflected that some staff went over and above the expectations of the patient. The report also reflected some patients reported it depended on who you saw as to the level of service received. The highest ratings recorded were 5 and the lowest was 3. There were no ratings given by patients below 3.



## Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

Source	Feedback
Interviews with patients.	Patients we spoke with were positive about the caring nature of staff both clinical and non-clinical. They told us staff would go out of their way to help them.

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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 (01/01/2022 to 30/04/2022)	92.0%	92.0%	89.9%	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 273 patients (2.5% of the practice list size) registered as carers.
How the practice supported carers (including young carers).	Carers were identified through registration processes and by the clinicians/social prescriber during consultations. Information with support and details of other agencies was given to carers to ensure they had access to any support they needed.



How the practice supported recently bereaved patients.	The practice had systems within the practice to identify bereaved patients and ensure that they were contacted by a GP or nurse. Appointments were made to ensure they were supported during this difficult time.
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### Privacy and dignity

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

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

## Responsive

**Rating: 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:	

### Practice Opening Times

Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm

Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Telephone lines are open 8.30am to 1pm and 2pm to 6pm Appointments available:	Throughout the day and varied depending on clinicians

**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 the community services to discuss and manage the needs of patients with complex medical issues. This included specialist diabetic nurses and community mental health workers.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

**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

**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)	69.0%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	56.0%	61.7%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	63.5%	59.8%	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)	66.8%	77.0%	71.9%	No statistical variation

#### Any additional evidence or comments

The practice told us they continually monitored access to clinical staff. GPs maintained oversight of their patient list and managed patients in ways that worked for the patient, such as those patients experiencing poor mental health. They had clear oversight and worked closely with other staff such as advance nurse practitioners and an emergency paramedic to ensure patients were followed up appropriately and in a timely way.

Source	Feedback
CQC - Share my care.	We received feedback from patients with the majority of comments being positive about the care and kindness shown by practice staff. We did receive some feedback relating to communication of some staff with patients. We gave this feedback to the practice who were already aware. The practice had a process where staff had been made aware of this and were supported to use as reflective learning in their appraisals and to look at ways to change their style.
NHS.uk website (formerly NHS choices)	There were 3 comments on NHS choices. Two of these comments were positive about the practice and 1 was negative. The negative comment was in relation to communication for patients no longer in the practice area.
Care home representatives	We had feedback from the representatives of some care homes for whom the practice delivered services. These representatives reflected that the practice carried out regular visits as required but that at times, there were long waits to get through

	to the practice. In addition, there was feedback from some care home staff that some clinical staff were more responsive than others. However, all patients received the care and treatment they required.
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### 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.	18
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.	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
Patient complained that antibiotics had been removed from the repeat medicines list	Detailed letter from one of the GPs which gave details of the clinical rationale for prescribing antibiotics.
Relative complained about communication held between GP and patients' parent.	Detailed letter from the GP involved including an apology. We saw the GP had taken this to a practice meeting and discussed with partners. Reflection had been included in the GP appraisal and communication tools in place.

**Well-led**

**Rating: Good**

### Leadership capacity and capability

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

	Y/N/Partial
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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: Staff we spoke with told us the leaders worked within the cohesive teams and were visible and approachable.	

### 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

### Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	

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

Source	Feedback
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Staff feedback from interviews and questionnaires	Staff we received feedback from was positive in respect of the practice culture. They told us there was an openness within all the leaders and there was cohesive teamwork. Staff told us they felt listened to and where appropriate actions were taken. Staff reflected they were aware of changes made as a result of complaints or significant events but told us they did not have whole team meetings. We discussed this with the management team and GP partners who told us this was something that used to happen but had, due to time constraints, ceased. They told us they would review this and consider reinstating these on a quarterly basis.
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**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: Our last inspection of the practice was November 2018, and the practice was rated as good. At this inspection we found the practice leaders and management team had continued to monitor their performance and identify areas where backlogs or delays had occurred. The practice demonstrated the areas that required addressing such as backlog of long-term medicines reviews was known to them and was being addressed. These areas of work relied on the recovery from the COVID-19 pandemic and staff shortages.	

**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:	

The practice had system and processes in place to monitor and manage risks. We found the systems were effective in most areas, but the legionella risks had not been wholly mitigated. A detailed risk assessment had been undertaken and actions completed, however, there was not a regular water temperature testing system in place to mitigate risks of legionella developing (regular water samples showed there was no legionella present in the water system). Immediate action was taken to implement a system to record water temperatures and evidence was shared with us.

**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

**Governance and oversight of remote services**

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

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

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

	Y/N/Partial
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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

#### Feedback from Patient Participation Group.

Feedback
A Patient Participation group had recently formed to work with the practice and to ensure the patient voice was heard. We spoke with 3 members of the group who were positive in their feedback. They told us the practice management team and GPs listened to feedback they gave and also discussed the challenges the practice staff faced on a daily basis. The group had discussed and agreed the objectives of the group and how to communicate more widely with patients. Ideas such as a news article in the local parish magazine had been discussed. The group and the practice also discussed ways to support vulnerable patients living in the area. The members were positive about future meetings and were looking at ways to support the practice further.

#### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice staff and GPs told us they were supported in their learning and development. The practice was a training practice, and the skills of the GP trainers were also used to ensure other clinical staff had reflective learning. Non-clinical staff told us they were given opportunities to develop skills and change roles when opportunities were available.	



## 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 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.