

Care Quality Commission

Inspection Evidence Table

Prospect Surgery (1-549668039)

Inspection date: 24 March 2022

Date of data download: 24 February 2022

Overall rating: Good

At our July 2021 inspection serious concerns were identified with regard to the safe care and treatment of patients, and the overarching governance of the practice. There was a lack of monitoring, risk assessments, record keeping and governance arrangements supporting the delivery of safe care and treatment. We were not assured that the service was safe. The practice was rated as inadequate overall. At this March 2022 inspection, we saw evidence of improvements in all of these areas previously identified. We have now rated this practice as Good, overall.

Safe

Rating: Good

In July 2021 we rated the practice as inadequate for providing safe services because high-risk medicines were not being monitored in accordance with current guidelines. Some patients had been co-prescribed medicines outside of manufacturers' guidelines and there was no evidence that the risks associated with this prescribing had been considered. There was a lack of structured medication reviews. Records of staff vaccinations were not held. Safeguarding processes needed to be improved. At this March 2022 inspection, we saw evidence of improvements in all these areas. We have now rated this practice as good for providing safe services.

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

Safeguarding	Y/N/Partial
<p>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.</p>	<p>Y</p>
<p>Significant improvements in safeguarding were evident since our previous inspection:</p> <ul style="list-style-type: none"> • There was a clinical practice lead for safeguarding children and another for safeguarding adults. The GPs also deputised for each other in these roles. The practice had also appointed named administration staff leads and deputies for safeguarding so that there was always a safeguarding contact working in the practice who could deal with safeguarding concerns. • The practice had systems and processes in place to ensure patients were safeguarded from harm. The practice had used the Royal College of GPs' safeguarding toolkit to review and update its safeguarding processes and policies. It had also asked the local CCG Safeguarding Lead to review its safeguarding policies. • Safeguarding concerns were escalated to the Safeguarding Lead and any action required was taken (for example, a referral to Social Services). • Staff we spoke with were aware of the practice's safeguarding policies. • The practice demonstrated a good awareness of safeguarding risks specific to its patient population. For example, the practice had a higher than average incidence of Female Genital Mutilation (FGM). It has discussed FGM cases with the community midwifery team. The practice had completed an audit on FGM coding to ensure that the relevant clinical codes and alerts had been added to the records of patients who have experienced FGM, and their female family members. • The practice maintained a register of vulnerable adult patients with safeguarding concerns. A risk assessment using an Ardens template (Ardens is a type of clinical decision support tool which works with the practice's electronic patient records' system) was used for these patients to identify if they needed a referral to Social Services. Recalls were put in place to review these risk assessments. Action was also taken to review risk assessments if information had been received from third parties (for example, local care homes or accident and emergency departments). • Records had been coded to highlight patients with safeguarding concerns to ensure that other services, such as Out of Hours who may have been accessing patient records were aware of any safeguarding issues. The practice used the Ardens Safeguarding template to record safeguarding multidisciplinary team meetings and events, and we saw evidence of this template being used during our remote records review. • The provider could articulate clear examples of safeguarding actions taken, during discussions at our inspection. • The practice had a policy for children and vulnerable adults who had not been brought to appointments at the surgery and in secondary care. Patients who missed appointments at the surgery were contacted to find out why and were offered another appointment. Action was taken to address any safeguarding concerns identified. The reception staff would identify any safeguarding concerns from letters from secondary care and escalate these to clinicians. • Meetings had begun to take place every two months with the health visitors to discuss child safeguarding. Health visitors were contacted directly if there were any urgent safeguarding issues with children. Safeguarding cases were also discussed at the practice's clinical meeting which was held every two weeks. • The administration team ran searches every week to identify any new safeguarding cases. • GPs attend strategy meetings (these are multidisciplinary team meetings to decide a joint response to safeguarding concerns) and evidence of this was seen during our remote records review. 	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> Five records were reviewed for children with safeguarding issues identified from the practice's clinical system. Evidence was seen of pertinent information sharing, and of GPs attending multidisciplinary meetings. Safeguarding alerts and codes were seen on all the safeguarding records we looked at, and on the records of the child's parents and siblings. We reviewed three records of adults with safeguarding concerns identified from the practice's clinical system. Safeguarding alerts and codes were seen on all the adult records we reviewed. The provider kept a register of patients who had been identified for early help interventions 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We reviewed three recruitment files on the day of our inspection. The provider had introduced a system to maintain information about staff vaccination status since our July 2021 inspection. This included risk assessments and reasons where staff had chosen not to have certain immunisations. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: October 2021	Y
There was a fire procedure.	Y
Date of fire risk assessment: reviewed and updated in June 2021, December 2021 and March 2022. Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: An evacuation drill was completed on 23 March 2022.	

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
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
Explanation of any answers and additional evidence:	

We saw evidence of infection prevention and control (IPC) audits. We saw that identified actions had been addressed. There was a lead clinician for IPC who could describe and demonstrate their role. We saw evidence that this was interwoven into the daily running of the practice.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke to could describe the process for identifying deteriorating patients. There were clear visible pathways (including for sepsis) displayed prominently in the administrative and receptionist work areas. Staff had also been trained in care navigation.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw positive examples of appropriate documentation in clinical records, during our remote records review. There was no backlog of clinical tasks or test results as these had been actioned in a timely manner. There was evidence of appropriate interagency information sharing.</p>	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.87	0.92	0.71	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). (01/10/2020 to 30/09/2021) (NHSBSA)	8.7%	9.5%	9.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2021 to 30/09/2021) (NHSBSA)	5.75	5.49	5.32	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	271.3‰	243.9‰	128.1‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	0.81	0.57	0.63	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	8.2‰	6.2‰	6.7‰	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.	Y

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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 Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. Improvements in high-risk drug monitoring were seen compared with the last inspection. There was a protocol in place to ensure patients prescribed any high-risk medications were up to date with their monitoring. The CQC searches showed that: <ol style="list-style-type: none"> a. Lithium (A medicine used to treat serious mental illness): All monitoring checks were up to date for all patients. b. Spironolactone (A medicine used to treat heart failure and control blood pressure): All monitoring checks were up to date for all patients. c. ACE inhibitors/ARBs (Medicines used to control blood pressure): One patient potentially had not had kidney function checks in the last 18 months. However, this patient was working abroad, and we saw that the practice had taken action by stopping the prescribing of this medication until the patient was able to attend for blood tests. d. Warfarin (A medicine used to thin the blood to reduce the risk of stroke and blood clots): we saw that four out of 27 patients potentially had not had an INR result recorded in the last 56 days (the International Normalisation Ratio (INR) is a test carried out at regular intervals to determine the dose of warfarin to be prescribed). However, all these patients had ceased taking Warfarin, as they had been switched to another blood-thinning medication that does not require INR checks. e. Direct Oral Anti Coagulants (Medicines used to thin the blood to reduce the risk of stroke and blood clots): All patients were up to date with monitoring checks and had had 	

Medicines management	Y/N/Partial
<p>creatinine clearance levels (a specific type of blood test) recorded to assess their kidney function to ensure that they were on the correct dose.</p> <p>2. The practice had introduced a protocol, since our previous inspection, for high-risk drug monitoring. Evidence was seen of the process that was now in place for monitoring Disease Modifying Anti Rheumatic Drugs (DMARDs) which are medicines used to treat inflammatory conditions such as rheumatoid arthritis:</p> <ol style="list-style-type: none"> a. Methotrexate: All patients were up-to date with monitoring checks and the day of the week on which this medication should be taken was recorded on all prescriptions reviewed. This was identified as an area for improvement from our inspection in November 2021. b. Azathioprine: All patients were up-to-date with monitoring checks. c. Leflunomide: All patients were up-to-date with monitoring checks. <p>3. The practice's prescribing of Pregabalin and Gabapentin (medicines generally used to treat nerve-related pain) was slightly higher than the CCG average. The practice had audited its prescribing of Pregabalin and Gabapentin. This audit showed that the practice had reduced its prescribing of Pregabalin and Gabapentin from 213 prescriptions in the first quarter of 2021 to 165 prescriptions in the third quarter of 2021.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	10
Number of events that required action:	8

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

Event	Specific action taken
Patient was prescribed an antibiotic which they had an existing documented sensitivity to.	Discussed in a clinical meeting within days of the event. All clinicians reminded of the importance of checking patient records for documented sensitivities and allergies. The practice acted promptly and the patient was unharmed by the error.
Patient attended the practice and was very agitated, shouting and swearing before their appointment. A staff member calmed the patient down, before going in to see the GP who was able to help them.	A positive outcome was recorded as the patient was able to receive the care and treatment needed, once they had been assisted to regulate their behavior.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: The practice has a process in place for managing and taking action in response to safety alerts. The searches identified that the practice was taking appropriate action in response to new and historical safety alerts, for example, sodium valproate in women of childbearing age.	

Effective

Rating: Good

At our July 2021 inspection, we rated the practice as inadequate for delivering effective services. This was because, at that time, patients' needs were not being assessed, there was a lack of appropriate monitoring, data for screening was lower than national targets and there were no plans in place to improve this. We were not assured that the practice was providing effective care to patients. At our March 2022 inspection we saw that improvements had been made in all of these areas. We have now rated the practice as Good for providing effective services.

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

Effective needs assessment, care and treatment

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

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

The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y

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.
- 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 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 Primary Care Network employed a mental health worker, and this allowed swift referral for the practice's patients identified as needing this support.

Management of people with long term conditions

Findings

- The records review showed that patients were generally being managed appropriately and having regular long-term condition reviews.
- Chronic Kidney Disease stages four and five: All patients had had blood pressure and kidney function monitoring in the past 18 months.
- Asthma: 21 patients had been identified as having had two or more courses of oral steroids for asthma exacerbations in the last 12 months. Of these 12, we reviewed five patient records. All five of these patients had had an asthma review in the last 12 months. Evidence was seen of patients being given written personalised asthma action plans. Three patients had been followed up after the course of steroids and treatment had been stepped-up, where appropriate. One patient was being prescribed oral steroids on a repeat prescription without being reviewed, but the practice had taken action and removed the steroids from the patient's repeat medication list.
- Hypothyroidism: We saw that two patients had been identified as being overdue thyroid function checks. However, in both these cases, evidence was seen of the practice attempting to contact these patients multiple times to book monitoring checks. The practice had also stopped one patient's thyroid medication as they had not had monitoring checks done.

- Diabetes: We saw that 25 patients had been identified as having poor HbA1c (an indication of diabetic control, over time) and diabetic retinopathy. Of these 25, we looked further into five patient records. Evidence was seen in all cases of the practice having taken action in response to abnormal HbA1c results, and either increasing the patient's diabetic medication, or referring them to the community or secondary care diabetes teams. We saw that one patient had been reviewed by a nurse on the day of the inspection and was noted to have a blood pressure reading of 190/100 which is significantly elevated. The patient had been booked to have their blood pressure and additional monitoring checks six days later. However, there was no documentation about whether the patient had been assessed for any serious signs and symptoms associated with high blood pressure, to see if an urgent same day assessment in secondary care was indicated as per NICE guidance. However, in mitigation of this risk, the patient was on two blood pressure lowering medications and had had elevated readings on other occasions which could be due to 'white coat' hypertension. This finding was raised with the practice who were going to investigate the reasons behind the clinical decision and identify if any immediate follow up was required.
- Structured medication reviews were now being performed. This was an improvement from the last inspection. Examples of these were seen during the records review including discussions regarding compliance and side effects as well as checks on monitoring.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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 asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	70	75	93.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	56	64	87.5%	Below 90% minimum

The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	55	64	85.9%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	56	64	87.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	69	81	85.2%	Below 90% minimum

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

Any additional evidence or comments

We discussed these below-average data sets with the provider. They could clearly demonstrate their attempts and actions to contact patients and carers directly to highlight the importance of childhood immunisation and to encourage them to attend for a vaccination. The practice maintained an active register of children and families with whom they were in active contact, regarding the immunisation schedule. We saw that many of the children on the data sets had moved to the UK from abroad where vaccine schedules were different. As such, the children were too old to meet the QoF requirements before they had registered with the practice. This had distorted much of the data and had given the appearance of low uptake rates.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 30/06/2021) (Public Health England)	49.7%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	59.0%	59.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	59.1%	66.8%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE)	59.1%	61.1%	55.4%	No statistical variation

Any additional evidence or comments

The provider had made a significant effort to increase its cervical screening uptake since our previous inspection. They had recruited a new practice nurse and ensured they were prioritised for achieving all cervical screening training in order to carry out their role and improve these targets.

Practice derived data (source: How Am I Driving?) indicated that the most recent data available had improved. The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within 3.5 years for women aged 25 to 49, was 67% and within 5.5 years for women aged 50 to 64 was 85%.

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:

The practice was engaged in audit and quality improvement work to improve patient care. Examples of seven good quality audits were seen, including Female Genital Mutilation, two-week-wait referrals and unplanned admissions to secondary care.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

The provider was clear about the importance of protected time for its workforce. For example, nurses whose role it was to carry out environmental safety checks every day received three sessions of protected time, per day, to check safety and resuscitation equipment and restock clinical supplies to improve the delivery of safe care and treatment. Administrative staff had protected time each week to run searches for patients on high-risk medications who needed monitoring.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-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

Explanation of any answers and additional evidence:

Our March 2022 inspection showed that there were no potential missed diagnoses of chronic kidney disease (CKD) or diabetes, identified through our remote records' searches. This was an improvement from our July 2021 inspection.

Consent to care and treatment

The practice 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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Clinicians had completed Mental Capacity Act training. Training records we reviewed confirmed this. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR): The practice had a recall system in place to ensure that DNACPRs were reviewed every 12 months. We reviewed four records which contained DNACPRs. Evidence was seen of mental capacity assessments and discussions being had with patients and their family members about DNACPR decisions. However, the DNACPR forms had not been completed fully as some "Yes/No" tickboxes had not been checked in the sections relating to discussions about the DNACPR. The practice should improve recording of DNACPR information ensuring that all forms are completed fully. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgmental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
<p>Explanation of any answers and additional evidence:</p> <p>In discussions with staff, there was a demonstration that they understood the needs and the culture of the practice population.</p> <p>Staff had recently undergone Dementia Friendly training and were awaiting accreditation as a Dementia Friendly practice.</p>	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	81.0%	88.9%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time	77.0%	88.4%	88.4%	Tending towards

Indicator	Practice	CCG average	England average	England comparison
they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)				variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	91.9%	95.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	78.1%	83.2%	83.0%	No statistical variation

Any additional evidence or comments

- The practice's comprehensive set of surveys and results were to be used as drivers for improvement in identified areas.
- All of the administrative and reception staff had undergone customer service training, and many had work experience in customer facing roles. This was seen as an important quality by the provider, in establishing a good rapport with patients.

Question

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

Y/N

Y

Any additional evidence

- The provider had undertaken a range of surveys to ascertain patients' views about its services. An anticoagulation survey was carried out in 2021. It was applicable to patients who were currently using or had used the practice's anticoagulation service within the previous 12 months. The survey had a response rate of 72.5% and showed that 57% of respondents rated the service as 'excellent'.
- In the practice's general patient survey of 2021, 91% of all patient ratings indicated responses of 'good', 'very good' or 'excellent'. The practice had seen a slight decrease in some satisfaction scores, against the backdrop of a global pandemic. We saw actions identified for onward improvements, for example, improvements to the telephony system.
- In January 2022 the provider ran and collated the results of a staff survey within the practice. We saw a list of actions identified for further improvement as a result of this work.

Involvement in decisions about care and treatment

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

Y/N/Partial

Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	93.1%	92.9%	92.9%	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
Explanation of any answers and additional evidence: The practice told us they struggled to provide cervical screening information to their Czech-speaking patients, as these leaflets were not widely available. But in all other cases, they provided a wide range of health promotion information leaflets in many languages.	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 17 carers which equates to 0.25% of the practice patient list. The practice told us they will consider more ways to ensure patients are accurately reporting their caring roles and responsibilities.
How the practice supported carers (including young carers).	The practice offered an annual review to all carers, including young carers.
How the practice supported recently bereaved patients.	The practice sent a sympathy card to bereaved patients which included details of bereavement services they could access, if desired.

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

Practice Opening Times

Day	Time
Opening times:	
Monday	8.00am – 6.00pm
Tuesday	8.00am – 6.00pm
Wednesday	8.00am – 6.00pm
Thursday	8.00am – 6.00pm (plus extended access from 7.00am)
Friday	8.00am – 6.00pm (plus extended access from 7.00am)
Appointments available:	
Monday	8.10am – 5.50pm
Tuesday	8.10am – 5.50pm
Wednesday	8.10am – 5.50pm
Thursday	7.10am – 5.50pm
Friday	7.10am – 5.50pm

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.
- Additional nurse appointments were available for school age children so that they 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 to all patients at additional locations within the area, as the practice was a member of a GP federation.
- 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.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	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	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>The practice had recently switched over to a cloud-based telephony system which enabled call recording and had a total of 12 incoming lines to the practice. This had improved the ability of patients to effectively contact the practice by telephone.</p>	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	88.5%	N/A	67.6%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	74.8%	69.6%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	86.5%	66.4%	67.0%	Variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	92.0%	82.2%	81.7%	Tending towards variation (positive)

Source	Feedback
NHS website	There were five reviews left by patients on NHS website in the preceding 12 months. All five were negative about access to appointments and quality of service. The practice had responded to three out of these recent reviews.

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.	3
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
Explanation of any answers and additional evidence: We saw evidence of team-wide discussion and learning from complaints.	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient was unhappy with ongoing care from a GP	The GP spoke at length to the patient to try and elicit the main concerns. Agreed to make a private referral, at the patient's request.

Well-led

Rating: Good

At our July 2021 inspection we rated the practice as inadequate for the provision of well led services. We found that leaders at the practice could not demonstrate that the governance, risk management, performance, and overall strategy ensured high quality and sustainable care. At that time, the overall governance systems were ineffective. At our March 2022 inspection we saw that improvements had been made to all of these systems and overall governance had improved. The practice is now rated as Good for providing well led services.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>In July 2021 we identified areas of concern with regards to safety and governance at the practice and took steps to ensure that risks to patients would be reduced. In December 2021 we reinspected the practice to monitor their progress towards compliance with the regulations. At that point it was evident that the provider understood the challenges and was beginning to take the necessary actions for improvement. At our March 2022 inspection we saw that the trajectory of improvement had continued, and all new systems of governance were being firmly embedded in the daily running of the practice.</p> <p>The development of all staff has allowed the workforce to take ownership of the new systems and there was a sense of a shared culture of improvements. For example, administrative staff had been upskilled to run clinical reports which identified any patients who needed to be contacted for monitoring and review. The staff member was afforded protected time to complete such work each week and took pride in doing this to the best of their ability.</p>	

Vision and strategy

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

	Y/N/Partial

The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	

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: Staff we spoke to told us they knew how to raise concerns and felt able to do so. There was evidence of team-wide discussions when things went wrong, and a culture of openness was beginning to emerge. The provider told us that the workforce was beginning to feel more confident about a 'no blame' culture as it transitioned more towards a learning culture.	

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

Source	Feedback
CQC staff questionnaires	<p>Questionnaires we received from staff were predominantly positive. Staff told us:</p> <ul style="list-style-type: none"> The atmosphere within the practice had improved considerably over the preceding few months. There was now an enthusiastic team and communication had improved within the team. Some staff told us they had an excellent relationship with their manager and all members of the clinical team, who were very approachable. Staff were valued and views were taken on board by a very supportive manager and supervisor. The atmosphere was positive, and it was an enjoyable place to work.

	<ul style="list-style-type: none"> • Some staff told us they could approach management and supervisors with any problems and would always be supported. • The partners were also very supportive and would give their advice and help to support staff in any situation. • However, one respondent felt that all of the changes had been driven by managers and leaders and had not come in partnership with staff.
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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
Explanation of any answers and additional evidence: We saw that numerous governance structures and systems had been developed and embedded into practice which were beginning to contribute to the safety and effectiveness of patient care. For example, high-risk drug monitoring, safety alerts and medication reviews.	

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 provider could demonstrate at our March 2022 inspection that the reduction of risk was a prominent factor when developing protocols, making decisions and taking action within the clinical setting.	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic.

	Y/N/Partial
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The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: The provider had successfully adapted to the new model of telephone first during the pandemic and was continuing to manage the hybrid approach of face-to-face, telephone consultations and electronic consultations. They showed an awareness for the digitally excluded, and those who were subject to language barriers for example, by providing numerous different systems for repeat prescription requests.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: We saw that the provider had created a new policy for the reporting of statutory notifications to CQC, as this was not previously in place.	

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

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

Feedback from Patient Participation Group.

Feedback
Members of the PPG told us that they do feel that their comments are listened to and taken seriously, that the practice is open and honest. We were also told that the provider shares information, shares examples of mistakes and learning from complaints and incidents.

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

Examples of continuous learning and improvement
Following our July 2021 inspection which identified significant concerns, the provider acted promptly to introduce robust systems of governance and safety, and could demonstrate at our March 2022 inspection that they had embedded these into practice. The practice culture had become focused upon learning

when things went wrong and working towards sustainable quality improvements and all departments of the practice were aligned in this trajectory.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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