

Inspection Evidence Table

Arcadian Gardens Surgery

(1-557402877)

Inspection Date: 19/12/2023

Date of data download: 15/01/2024

Overall rating: Good

During our previous inspection in October 2022, we found that the practice did not have clear and effective systems in place for managing risks. For example, there was a failure to act on previously identified risks relating to an absence calibration of medical devices, monitoring of emergency medicines and periodic infection prevention and control audits. Additionally, we found that the governance arrangements did not work effectively and placed patients at risk. For example, systems for monitoring cancer referrals and recording cervical smear test results generated inaccurate search results.

At this inspection, we found that the practice had rectified the issues mentioned above. The practice had completed appropriate risk assessments and all certifications seen were in-date. Additionally, the practice had introduced standard operating procedures (SOPs) to monitor cancer referrals and record cervical smear test results, with designated staff listed in these fully aware of their roles in regard to monitoring.

Context

Arcadian Gardens Surgery is located in Haringey, North London and has a patient list of approximately 8,000. The practice is part of the North Central London Integrated Care System and has a deprivation score of 4 out of 10 (1 being the most deprived). Arcadian Gardens Surgery cares for a diverse population (with approximately 29% of its patients from Black and minority ethnic backgrounds).

The practice holds a General Medical Service (GMS) contract with NHS England. This is a contract between general practices and NHS England for delivering primary care services to local communities. The practice is open between 8:00am and 6.30pm Monday to Friday. Extended hours surgeries are also offered Monday to Friday from 6.30pm to 8:30pm and 8:00am to 8:00pm at weekends (via local GP access hubs). Outside of these times, patients are referred to a local out-of-hours provider. The services provided include child health care, ante and post-natal care, immunisations, sexual health and contraception advice, and management of long-term conditions. The practice provides onward referral for smoking cessation.

There are two GP partners (one female, one male), one female practice nurse, one male advanced nurse practitioner, two physician associates (one male, one female), two clinical pharmacists (one male, one female), a Practice Manager and a range of administrative and reception staff. The practice is registered with the Care Quality Commission to provide the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

Safe

Rating: Good

- During our previous inspection in October 2022, we found that the practice did not have effective processes for managing risks. At this inspection, we found that the practice had ensured all appropriate risk assessments had been completed, and that action plans were devised and completed where indicated.
- The practice had completed infection prevention and control audits and taken appropriate actions where concerns were identified.
- The practice had actioned several items in relation to their fire risk assessment. For example, servicing the fire extinguishers and fixing emergency lighting.
- When things went wrong, there were systems in place to review, investigate and learn.
- Systems were in place to act on safety alerts.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However, not all staff had completed the appropriate safeguarding training applicable to their roles.

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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice maintained adult and children safeguarding records, with accompanying actions and outcomes documented. • Evidence was seen on the electronic clinical records system of safety alerts. Patients highlighted as being vulnerable were given priority access to appointments at the practice. • We reviewed staff personnel records for 2 clinical and 2 non-clinical staff members. During the site visit, we found that 1 clinical staff member did not have the appropriate level of children’s safeguarding training applicable to their role. Following inspection, the practice sent evidence that this had since been completed. One non-clinical staff member had out of date adult safeguarding training. Another non-clinical member of staff did not have the appropriate level of children’s safeguarding training applicable to their role. Following inspection, the practice sent evidence that this had since been completed. 	

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
Explanation of any answers and additional evidence:	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment:	12 December 2023
There was a fire procedure.	Y
Date of fire risk assessment:	11 January 2023
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • An external contractor had completed a health and safety risk assessment on 7 October 2022. A follow-up visit was scheduled for 13 December 2023, and we saw evidence the practice had confirmed this with the contractor. However, no formal report was completed as the external contractor had recommended the practice to review items from the previous report. The next scheduled health and safety risk assessment was therefore booked in with the external contractor for February 2024. • We saw evidence the practice had actioned items from their previous health and safety risk assessment and fire risk assessment. • The practice completed an in-house health and safety risk assessment on 12 December 2023. 	

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:	23 November 2023
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: <ul style="list-style-type: none"> • The practice completed in-house infection and prevention control (IPC) audits biannually. 	

- We saw evidence of an action plan, of which several items remained outstanding. However, designated staff members were assigned to specific tasks, and reasonable timeframes were allocated for completion. The IPC audit was scheduled to be repeated on 17 January 2024.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • All 4 staff personnel files we reviewed (2 clinical and 2 non-clinical members of staff) had completed basic life support training. • Non-clinical staff we spoke with during the site visit were able to clearly explain how they would identify a deteriorating patient and the actions they would take if such circumstances arose. • We saw evidence that all staff had received sepsis awareness training. Sepsis occurs when the body has an extreme response to infection, which can be life-threatening if not treated promptly. 	

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
Explanation of any answers and additional evidence:	

- We found the practice had an effective system in place for managing test results on their electronic clinical correspondence system.
- Pathology results were reviewed the same working day by the duty GP.
- The practice had a system in place to monitor 2 week wait (2WW) referrals, where a designated member of staff completed a weekly search and would contact any patients who had not attended their appointments.

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) (01/10/2022 to 30/09/2023) (NHSBSA)	0.36	0.65	0.91	Significant variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2022 to 30/09/2023) (NHSBSA)	5.7%	8.8%	7.8%	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 (01/04/2023 to 30/09/2023) (NHSBSA)	4.17	5.49	5.19	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)	50.9‰	62.4‰	130.7‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2022 to 30/09/2023) (NHSBSA)	0.54	0.53	0.53	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)	7.0‰	6.0‰	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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches:</p> <ul style="list-style-type: none"> At our previous inspection in October 2022, we found issues with the signatory dates on some of the Patient Group Directions, which indicated there were periods where nurses did not have the appropriate authorisation to administer medicines. At this inspection, we did not find any issues with regards to the Patient Group Directions in place. The practice proactively monitored their prescribing of antibiotics and completed audits to ensure these were only prescribed when clearly clinically indicated. During our clinical records searches, we identified 9 patients prescribed azathioprine. Azathioprine is a medicine prescribed to suppress the immune system and is often prescribed to patients to treat inflammatory conditions. Patients prescribed this medicine requires monitoring to check their liver and kidney function, as well as their blood cell production. Of the 9 patients identified, we sampled 5 patient records. 4 out of 5 of these patients had received the appropriate monitoring. The remaining patient was overdue a blood test; however, the practice stated they were trying to reach this patient and would withhold or reduce the medicine until the monitoring had been completed. We identified 7 patients prescribed lithium (a mood stabiliser medicine). Out of the 7 patients identified, we reviewed 2 patient records. One of these patients had already been contacted by the practice to book in their monitoring, and the other patient needed contacting. There were no issues of potential patient harm identified. 	

- We identified 172 patients who had received a medicines review in the preceding 3 months. We sampled 5 of these patient records and found no issues of concern. The medicines reviews we sampled had documented the outcomes from the review and addressed required monitoring or changes to treatment.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	N/A
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	N/A
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	N/A
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	N/A
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	N/A
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	N/A
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	N/A
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	N/A
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	N/A
Explanation of any answers and other comments on dispensary services:	

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:	6
Number of events that required action:	6
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> All staff spoken with during the inspection were able to detail how and to whom they would raise concerns. The practice kept a log of significant events and detailed the actions taken as a result. We saw evidence that significant events were discussed as a routine item on the practice meeting minutes. 	

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

Event	Specific action taken
Failure of electronic door entry to practice.	Key safe installed.
Patient required nebuliser, but staff member initially struggled to locate appropriate mask.	Additional masks ordered, agreed new location of emergency keys to access emergency medicines stock units, mock run of event to be repeated to ensure changes implemented effectively.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Our clinical searches identified 11 patients prescribed teratogenic medicines who were of childbearing age. Teratogenic medicines have the potential to increase the risk of birth defects and developmental disorders when taken during pregnancy, especially during the first trimester. Of the 11 patients identified, 5 patient records were looked at. 4 of these 5 patients had documentation in their clinical records to evidence that the risk was discussed with the patient or alternative treatments considered. One of these patients had reached menopause, therefore such advice did not apply to this patient. 	

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.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Patients who were flagged as vulnerable (for example, being on the child or adult safeguarding lists) were given priority access to appointments.• Clinical staff were supported in completed continued professional development (CPD) and allocated dedicated time to such activities.	

Effective care for the practice population

Findings

- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice 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.

Management of people with long term conditions

Findings

- During our clinical records searches, we identified 5 patients who had received two or more courses of steroids for asthma exacerbations in the preceding 12 months. Steroids are medicines prescribed to reduce inflammation within the body. We sampled all five of these records and found that all patients had received their annual review and been followed up accordingly.
- We identified 205 patients who were prescribed medicine to treat hypothyroidism. Hypothyroidism is a condition in which the thyroid gland does not produce sufficient amounts of hormones for the body's needs. We sampled 5 patient records and found that all 5 patients had received the appropriate monitoring.
- We identified 21 patients with either stage 4 or 5 chronic kidney disease (CKD) - A condition in which the kidneys gradually stop functioning, with 4 or 5 being the most advanced stages of the disease. Out of the 21 patients identified, we sampled 5 patient records. All 5 of these patients had received the appropriate monitoring.
- We identified 511 patients who were diagnosed with diabetes. Patients with diabetes have blood tests to monitor their level of Haemoglobin A1c (HbA1c). HbA1c indicates a patient's average blood sugar over the preceding 3 months. If this value is above a certain limit, it indicates an increased risk of complications for those with a diabetes diagnosis. Sixty two out of the 511 patients identified had a last HbA1c which was elevated. We sampled 5 out of these 62 patient records and found all 5 patients had received the required monitoring.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	68	81	84.0%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	52	69	75.4%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	51	69	73.9%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	54	69	78.3%	Below 80% uptake
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)	46	62	74.2%	Below 80% uptake

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

Any additional evidence or comments

The practice was aware of its performance and was taking proactive measures in attempts to increase uptake. For example, a designated member of staff was assigned to contact the parents/guardians of eligible patients to invite them for their immunisations.

The practice had a comprehensive call / recall system in place to encourage uptake of childhood immunisations. A designated member of staff completed a search on the electronic clinical records system on a weekly basis to identify applicable patients and contacted parents/guardians of eligible children through a variety of means. If no contact was made during these times, nursing staff would liaise with health visitors where appropriate to follow up with children not brought to immunisation appointments.

The practice submitted unverified data which reported the uptake for childhood immunisations had increased in 4 out of the 5 indicators listed above. The results from this data were as follows:

- 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) – 87%
- The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) – 84%
- 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) – 85%
- The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) – 84%

Cancer Indicators	Practice	SICBL average	England	England comparison
Breast screening coverage: aged 53 to 70 years old (01/04/2022 to 31/03/2023) (UKHSA)	52.6%	N/A	66.6%	N/A
Bowel cancer screening coverage: aged 60 to 74 years old (01/04/2022 to 31/03/2023) (UKHSA)	60%	N/A	72%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	60.0%	55.7%	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). (6/30/2023 to 6/30/2023) (UKHSA)	65.7%	N/A	80.0%	Below 70% uptake

Any additional evidence or comments

The practice was aware of its performance and were taking proactive measures in attempts to increase uptake. For example, a dedicated member of staff was working additional hours to invite eligible patients in for their cervical screening. The practice was taking part in the Primary Care Network (PCN) smear project, in which 100 patients would be called each month and invited to book in for their cervical screening.

The practice identified that cervical smear uptake was particularly low in patients under 50 years old. Because of this, when new patients registered, eligible patients were asked on registration whether they were up to date with their cervical screening and encouraged to book in as soon as possible where indicated. The practice identified that language barriers and a lack of education were potential barriers, so had ensured that appropriate time was booked for appointments to allow for education to be provided to patients who may require this (and for it to be delivered to the patient in their preferred language).

The practice submitted unverified data which reported the uptake for cervical screening had increased in one of the indicators listed above. The results from this data were as follows:

- 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) – 73%
- The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 5.5 years for persons aged 50 to 64) – 86%

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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>Antibiotic prescribing audit:</p> <p>This audit was completed to ascertain the quantities of antibiotics currently being prescribed, and attempt to reduce the quantities prescribed in order to reduce the prevalence of antibiotic-resistance both for the individual and within the population.</p> <p>Two audit cycles were completed, and the results were as follows:</p> <p>First data collection (28/08/2022 – 28/09/2022):</p> <ul style="list-style-type: none">1496 patients seen, 122 of which were prescribed an antibiotic – 8.2% <p>Second data collection (01/10/2023 – 11/12/2023):</p> <ul style="list-style-type: none">3940 patients seen, 210 of which were prescribed an antibiotic. – 5.3% <p>The practice noted a 2.9% reduction in the amount of antibiotics prescribed between the periods of the two data collections.</p> <p>The practice reported that it will continue to run 6 monthly antibiotic prescribing audits, as well as discuss antibiotic prescribing at each clinical meeting. Prescribers were asked to complete the antibiotic stewardship self-assessment and encouraged to attend antibiotic management webinars.</p>	
Any additional evidence or comments	
<p>The practice has taken part in several quality improvement activities. For example, in the past 12 months, the practice has introduced 5 new alerts on the electronic clinical records system. Some examples of these alerts included staff alerts to book the correct appointment length for newborn 8 week checks with the GP, and to alert staff to the reason behind why safeguarding codes are applied to particular patient records.</p> <p>Another example of quality improvement which the practice has engaged in is the introduction of a service called “ChatDoc” - A text messaging-based service, which provided patients with a quicker and more convenient way of contacting the practice at any point during the day. The practice implemented this system in response to increased patient demand for appointments and to increase ease of access for patients. Additionally, ChatDoc was introduced to help ease the burden on reception staff having to take numerous calls,</p>	

particularly first thing in the mornings. All ChatDoc messages received by the practice were triaged on the same day and patients offered appointments within a fortnight, dependent on clinical need.

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:	

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
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Where indicated, clinical staff signposted patients to self-referral services within the locality (for example, bereavement or mental health support services). 	

Any additional evidence or comments

The practice utilised social prescribing through use of a nearby allotment, solely funded by one of the GP partners. This initiative was introduced to promote social inclusion, holistic-wellbeing and to be provided as either an adjunct or alternative to prescribing medicines. One of the GP partners was often there whilst patients were using the allotment, and supported patients in both a professional and moral capacity. Whilst this initiative was primarily targeted at patients experiencing poor mental health and who may have experienced negative side effects to pharmaceutical input, this was then extended to involving a local school to take part and grow vegetables, in attempts to encourage healthier lifestyle choices.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> During our clinical review of notes, we sampled 3 patient records where a DNACPR decision had been recorded. We found that patient views had been sought and respected, and that information had been shared with relevant agencies as applicable. 	

Well-led

Rating: Good

- During our previous inspection in October 2022, we found that the practice did not have effective governance arrangements, which placed patients at risk. Additionally, the practice did not have clear and effective processes for managing risks. At this inspection, we found the practice had introduced protocols in relation to the monitoring of cancer referrals and cervical screening results. The practice had also ensured all risk assessments were completed and up to date, and that any concerns highlighted were actioned appropriately.
- The practice involved the public, staff and external partners to sustain high quality and sustainable care having, for example, funding a local community allotment to promote patients' physical and mental well-being.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • All of the staff spoken with during the site visit reported they felt management were approachable and supportive. • The practice demonstrated awareness into the needs of the local population and adapted its service delivery to reflect this. For example, the introduction of the ChatDoc facility and the allotment programme. 	

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: <ul style="list-style-type: none"> • All staff spoken with during the site visit reported they felt listened to and that suggestions they made to management would be considered accordingly. 	

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: <ul style="list-style-type: none"> All staff spoken with during the inspection stated they knew how to raise concerns and to whom these would be reported. We saw evidence that apologies were made by the practice when things had gone wrong. For example, in the practice's significant events and complaints logs. 	

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

Source	Feedback
Staff interviews	Very good team, supportive and visible management, opportunities for career progression offered

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	

- At our previous inspection in October 2022, we found that there were issues with the monitoring of emergency medicines. At this inspection, we found the practice had implemented a system whereby the emergency medicines were checked monthly, and those medicines approaching expiry were flagged accordingly.
- At our previous inspection in October 2022, we also found issues with the practice’s monitoring of Legionella and equipment calibration. At this inspection, we saw evidence of a Legionella control policy and evidence of the practice having sent water samples for Legionella testing. Additionally, equipment calibration had been completed by an external contractor within the past year.
- At our previous inspection in October 2022, we found that the practice had not completed an IPC audit since 2019. At this inspection, we saw evidence that an IPC audit had been completed in November 2023 and that appropriate actions had been taken as a result.

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: <ul style="list-style-type: none"> • Since the last inspection in October 2022, the practice had been proactive in rectifying gaps in risk assessments. For example, the practice had taken action in relation to the health and safety risk assessment and legionella risk assessment. In addition, the practice had obtained a data protection risk assessment, and we saw evidence this has been discussed with stakeholders and staff at the practice. 	

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:	

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
Explanation of any answers and additional evidence:	

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
Explanation of any answers and additional evidence:	

Feedback from Patient Participation Group.

Feedback
We spoke with two members of the Patient Participation Group. We were told the practice actively sought out the views of the group and were able to identify specific instances where views and opinions influenced how services were delivered, including in the area of social prescribing where the group was closely involved in supporting a practice-led gardening initiative.

Any additional evidence

During the site visit, we spoke with two patients. Both patients reported difficulty with their mobility and stated the practice supported them and ensured any appointments they had were allocated on the ground floor. They also stated that the practice went above and beyond for their patients and that nothing ever felt too much trouble.

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: <ul style="list-style-type: none">We saw evidence of shared learning documented in the practice meeting minutes. For example, significant events and complaints would be shared within the team and any learning needs disseminated as needed.	

Examples of continuous learning and improvement

We saw evidence of action having been taken to improve cervical screening and child immunisation uptake. We also saw extensive evidence of how clinical audit had been used to improve patient outcomes.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

Glossary of terms used in the data.

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