

Care Quality Commission

Inspection Evidence Table

Lawrence Hill Health Centre (1-558155440)

Inspection date: 3 August 2022

Date of data download: 18 July 2022

Overall rating: Requires improvement

At our previous inspection of Lawrence Hill Health Centre in July 2019, we rated the practice as Requires improvement overall because:

- Improvement was required to their quality and outcome framework monitoring.
- Arrangements for storage of paper patient records were not sufficient.
- There were incomplete CQC registration processes for the partnership and registered manager.

At this inspection, the practice had taken action to address the issues found and were able to demonstrate actions had been completed. However, we have rated Lawrence Hill Health Centre as Requires improvement overall because:

- The practice did not have oversight of staff recruitment files including Disclosure and Barring Service (DBS) checks, vaccination records and mandatory training.
- Where new systems had been implemented, the practice could not always assure themselves that documentation was accessible.
- Senior leaders did not always have oversight of risk and review processes.

Safe

Rating: Requires improvement

At the inspection in July 2019, the Good rating for safe services was carried over from 2015. During this inspection, we have rated the practice as requires improvement for safe services because:

- Mandatory staff training was not monitored and in some areas staff were not up to date.
- Disclosure and Barring Service (DBS) checks and vaccination records were not held in line with guidance.
- Recruitment processes were not carried out in line with guidance.
- Prescribing of controlled drugs was not routinely monitored.

Safety systems and processes

The practice did not have 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.	Yes
Partners and staff were trained to appropriate levels for their role.	No
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	No
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had safeguarding lead GP's for both children and adults, who were aware of the risks and concerns surrounding Female Genital Mutilation (FGM). All staff were clear on processes on how to safeguard patient from abuse. They understood when and who to seek advice from where needed. The practice did not routinely have oversight of staff mandatory training. We requested evidence of training but was not available for us either before or during the inspection. Post inspection, we were provided with evidence which showed gaps in mandatory safeguarding training. For example out of 23 staff required to have level two safeguarding training, 13 were out of date for adult safeguarding and seven were out of date for child safeguarding. Gaining level three safeguarding training for staff had been a challenge for the practice. Out of 21 health care professionals, 12 were not up to date with adult safeguarding training. 19 were not up to date with child safeguarding. Post inspection we saw evidence which demonstrated the practice were contacting the local Integrated Care Board (ICB) for support on this. We were told by leaders that safeguarding concerns could be raised at the multi disciplinary team meeting, with social services and district nurses, which were held every six weeks. If information needed to be shared before this time they could contact them. We were informed that relevant information was shared at team meetings. The practice were unable to provide evidence that Disclosure and Barring Service (DBS) checks were carried out at the time of recruitment and they did not have oversight of this information. Since the day of inspection, the practice provided evidence that some staff had DBS checks in place. However, 14 members of staff, of which 9 were clinicians, did not have a DBS check on record. We saw evidence that these applications had been started since the inspection. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> During the on-site inspection, we found there was no consistent approach to managing recruitment checks and staff files. Of the three staff files we were able to view there were gaps in the information held. For example we could not view; signed contracts, proof of identification, qualifications, professional registration details or confidentiality policy statements. We discussed this with the provider who told us that in order for staff to be granted access to the practice systems, identification documents would have needed to be seen. However, this documentation was not held by the practice as part of their recruitment record. The practice were unable to provide evidence of staff vaccination in line with recommended guidance. In some personnel records, there was record of Hepatitis B immunity as a stand alone record. Post inspection we were sent a new process that the practice intended to follow which included the recording and documentation of staff vaccination profiles. However, this document did not contain information regarding all the relevant vaccinations in line with guidance. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 5 October 2021	Yes
There was a fire procedure. Date of fire risk assessment: November 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice employed an external company to oversee the fire safety. We saw evidence that regular fire drills and evacuations had taken place. There was one outstanding action from this risk assessment which was in progress. 	

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.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 21 June 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Explanation of any answers and additional evidence:

- Senior leaders did not have oversight of staff mandatory training. We requested oversight of training records as part of our pre-inspection information and again during onsite. It was not available for us at either opportunity. Post inspection we were sent a training matrix which revealed there were some gaps in staff training for infection prevention and control (IPC). Five out of 25 staff members were not up to date with level two IPC training.
- We saw evidence the practice had acted on an infection prevention audit carried out by the Integrated Care Board (ICB).
- The practice carried out internal IPC audits into handwashing and sharps box safety.

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had an induction programme for new starters, however this programme was not embedded practice. We were told by staff they received a tailored induction from their line manager but this was not formalised. There were no completed induction documents available to evidence the induction training provided to staff. • The practice held an emergency trolley that contained appropriate medications and equipment which was risk assessed and checked in line with guidance. • Since the date of inspection, we were provided with information on staff mandatory training. Seven out of 37 staff members were not up to date for resuscitation. 	

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had a system for processing referrals, however there was no oversight of this referral list. The practice did not routinely check these patients had been offered appointments or had attended appointments in a timely way. The practice told us they advised the patient to contact them if they did not received an appointment within the advisory two weeks and hospitals informed them if a patient did not attend.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation, however these were not effective.

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) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.58	0.67	0.79	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	11.3%	9.5%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	4.26	4.51	5.29	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	62.2‰	92.3‰	128.2‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	1.09	0.53	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	6.0‰	5.0‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial

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.	Yes
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	No
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Since the last inspection in July 2019, we found the practice has improved their hypnotic medicines prescribing. • We reviewed the Patient Group Directions (PGDs) at this practice and found 11 of these were not in line with guidance. This included clinicians names which had been added post authorisation or a missing signature from an authorising manager. (PGD's provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without the individual having to have the medication prescribed). Since the day of the inspection the practice has shown evidence of a new PGD protocol created in line with guidance and evidence that they have begun to rectify the issues we raised with them on the day of inspection. • Staff told us they had a named GP who they undertook verbal supervision with each week. The practice also had an open door policy for non-medical prescribers (NMP) to ask for support or advice where required. However, there was no formalised process for auditing how NMP's make their decisions and the types of medicines they were prescribing. • The practice told us they were not currently completing audits of controlled drug prescribing. They could not evidence the last time this had occurred. We discussed the benefits of this with the practice. 	

Medicines management

Y/N/Partial

Clinical searches by a Care Quality Commission (CQC) GP Specialist Advisor for this inspection showed patients received appropriate monitoring of their health and received a clinical review for long term conditions in most cases.

The reviews included in our searches included patients diagnosed with:

- Asthma who had had two or more courses of rescue steroids in the last year.
- Chronic kidney disease stage four or five, which is a reduction in kidney function, structural damage or both.
- Hypothyroidism, a condition where the thyroid gland does not produce enough hormones.
- Diabetic retinopathy whose latest HbA1C result was more than 74mmol/l. Diabetic retinopathy is a complication affecting vision that can arise in people who have diabetes. HbA1c is a blood test that can give a picture of someone's blood glucose levels over the previous two to three months and therefore an indication of the management of their diabetes.

Where there were gaps in monitoring of Hypothyroidism during the clinical searches, we had reassurance from senior leaders that this was acted on.

A CQC GP Specialist advisor found gaps in the monitoring of high-risk drugs including Methotrexate (used to treat autoimmune conditions), Lithium (mood stabiliser) and Spironolactone (used to treat heart failure). We discussed this with senior leaders who were aware their system did not allow them to pull through hospital results to their internal system. The practice were not routinely recording if they had viewed the relevant documentation to make safe prescribing decisions. The practice informed us that staff do review the hospital blood results before re-issuing and planned to improve this process going forward.

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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	30
Number of events that required action:	30
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was an open culture for the reporting of and discussion of incidents or near-miss incidents. • The practice used an online system for reviewing significant events and actions involving a template. However, some of the events we reviewed had very little or no information of the incident. Therefore we could not be assured of a consistent or thorough process for investigating significant events. It was not always clear what learning had occurred and how this would contribute to improving services. • The incidents we could view in full were actioned appropriately and discussions and learning occurred. These incidents were routinely taken to an internal significant events meeting for clinicians to discuss. 	

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

Event	Specific action taken
During monitoring of fridge temperatures, the practice found fridge three was repeatedly going out of range for short periods of time.	<ul style="list-style-type: none"> • Reviewed the data logger. • Followed protocol and guidance for vaccination temperatures. • Discussion with leaders. • Reviewed fridge audit process • Decommissioned the fridge.
A patient had displayed aggressive behavior towards staff.	<ul style="list-style-type: none"> • Patient removed from the building. • Police were contacted. • Patient was given a warning letter. • Improvements to zero tolerance policy.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> During clinical searches by a CQC GP specialist advisor, we could not see evidence of an embedded recall system for the monitoring of blood pressure for Mirabegron (a medicine used to treat overactive bladder, which has a common side effect of high blood pressure). However, we spoke to the practices pharmacist and they could evidence the protocol they had in place. This included running searches and contacting these patients, shown in an audit trail. 	

Effective

Rating: Requires improvement

At the last inspection in July 2019, we rated this service as requires improvement for providing Effective services because:

- Performance for childhood immunisations, cervical cancer screening and response to patients with long-term conditions remained below local and national averages.

Whilst the practice had implemented new processes to improve their data, we found new areas of Effective services that require improvement:

- Not all members of staff had received an appraisal.
- Oversight of non-medical prescribers was lacking sufficient evidence.
- Files relating to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were not always accessible to staff.
- The practice were unable to provide improved childhood immunisation and cervical screening uptake despite increased effort to provide accessible information and appointments.

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes

Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice was situated in a diverse demographic with complex health needs, however the practice had taken steps to ensure patients' needs were met.</p> <ul style="list-style-type: none"> • A specific protocol had been developed to support the transgender population in line with guidance from NHS England and the General Medical Council (GMC). • To ensure all their patients could access care during the COVID19 pandemic, they had enabled patients without telephones or internet access to make appointments by attending the practice. 	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice took part in the Safe Surgeries initiative which enabled patients to register without full documentation.
- Care for substance misuse patients was shared with Bristol Drug Project.

Management of people with long term conditions

Findings

- 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Review of patient records as part of the CQC remote clinical searches identified that in most cases patients on long term conditions received the required monitoring. Full details are under the medicines section of the safe domain.
- 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.
- Patients with asthma were offered an asthma management plan.
- The practice had access to mental health support and advice from an external Psychiatrist.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	121	131	92.4%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	87	127	68.5%	Below 80% uptake
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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	87	127	68.5%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	81	127	63.8%	Below 80% uptake
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	111	137	81.0%	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

This practice is situated in a highly deprived area serving a diverse population. At the last inspection in July 2019, we found child immunisation data was below the World Health Organisation (WHO) target. The practice is still below target, however they have taken the following steps to improve their data:

- A webinar was held in partnership with the Avon (LMC) and local Somali charity to explain the process of childhood immunisations including risks and myths.
- Continued to hold appointments outside school hours and remind clinicians to opportunistically discuss with parents and carers of patients due an immunisation.
- Had built a relationship with a Somali link worker to support communication and implemented the ability to block book appointments.
- Leaflets on immunisations printed in other languages which met the patients demographic needs.
- The practice employed staff from the Somali community.

The practice were not routinely monitoring any improvement to this data outside of the publication from NHS England and were therefore unable to identify on an ongoing basis whether their interventions were proving beneficial or identify what further work was required

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	63.0%	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) (UKHSA)	48.1%	61.4%	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) (UKHSA)	50.5%	66.7%	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) (UKHSA)	45.2%	58.4%	55.4%	No statistical variation

Any additional evidence or comments

At the last inspection in July 2019, the practice were not meeting the national target for uptake of cervical cancer screening. The practice had taken the following steps to improve this data:

- Offered practice cervical screening appointments which allowed patients to attend the practice and talk through the process, including timescales, without the pressure to have the procedure undertaken.
- Posters were displayed in the waiting room in alternative languages with staff photos on.
- Conversations with the practice link worker to improve relationships and trust.

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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

- We reviewed an audit regarding recording consent for procedures. This audit had been carried out twice six months apart. The first audit found out of 45 procedures reviewed 11 did not have consent recorded. As a result, all staff were advised to use a system template for recording procedures. In the second audit, results had improved and out of 56 procedures, two did not have consent recorded.
- The practice had been involved in a series of three quality improvement exercises known as “productive primary care” funded by the Integrated Care Board. The processes reviewed were medication request system, workflow document system and smoothing of patient flow. The exercises were overseen by external co-ordinators to examine systems and processes.

Effective staffing

The practice was unable 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.	Partial
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> During the inspection, leaders did not have oversight of staff personnel files. Whilst they held some documentation, it was not all stored in an accessible way. We were unable to view clinical registration details, mandatory training compliance and professional qualifications in some cases. We saw an example of the induction programme for new starters and staff told us their department manager was responsible for their induction. However, there were no completed copies for current staff. During interviews, clinical staff told us there was an open door policy for support and they had weekly meetings with a named GP to discuss clinical cases. However, there was no documentation to support this. We saw clinical appraisals were taking place, which gave line managers the opportunity to discuss performance. At the time of inspection, non-clinical staff had not received appraisals. However, we were sent planned dates and times for these to take place post inspection. All appraisals were planned to take place within three weeks of the on-site inspection. 	

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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Explanation of any answers and additional evidence:

- The practice displayed a variety of posters in their waiting room in different languages to meet the needs of registered patients. Campaigns and advice could be found on the website.

Consent to care and treatment

The practice was unable to demonstrate that it 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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial

Explanation of any answers and additional evidence:

- We reviewed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions which were recorded in patients clinical records. The practice used ReSPECT forms (documentation to support patients to make anticipatory decisions including resuscitation) to record these decisions in line with local guidance. During the inspection we found that whilst patients had been appropriately coded when they held a ReSPECT form, the documentation was not always attached to the patients' records. This meant decisions could not be viewed by GPs and clinical staff when required. The practice had recently developed a new system for how they managed DNACPR's and since the inspection provided us with an action plan and protocol for how they intended to manage this.

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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00- 18:30
Tuesday	08:00- 18:30
Wednesday	08:00- 18:30
Thursday	08:00- 18:30
Friday	08:00- 18:30
Additional hours three mornings a week	07:30-08:00
Appointments available:	
Monday	08:00- 18:30
Tuesday	08:00- 18:30
Wednesday	08:00- 18:30
Thursday	08:00- 18:30
Friday	08:00- 18:30

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none">• Patients had a named GP who supported them in whatever setting they lived.• The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.• The practice recognised religious and cultural differences and worked with other services to help patients feel safe and informed. For example adapting how cervical screening appointment to be information only and tailoring of information posters.• The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.• Early morning appointments between 07:30 and 08:00 were available three mornings a week to support children and patients of working age.

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people 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.
- The practice worked with a Somali link worker to provide information and accessible appointments.

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 and Improvement 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 minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • During the COVID-19, the practice continued to provide face to face access to appointments to meet their demographic needs. • Whilst on-site we saw that the practice were communicating reasons for change openly through posters and displays. 	

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)	63.0%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	73.0%	72.3%	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)	77.3%	67.4%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	76.2%	83.9%	81.7%	No statistical variation

Any additional evidence or comments

- There was information in the waiting room to tell people why they will not always need a face to face appointment.
- The practice had recently established a patient participation group (PPG). During the first meeting, most concerns raised were regarding access and the telephone system. The practice had already improved aspects of their current telephone system and had begun to make enquiries of acquiring an improved system.

Source	Feedback
NHS Choices	<p>We reviewed feedback from the NHS choices website from the last 12 months.</p> <p>There was a mixed set of reviews which have themes of:</p> <ul style="list-style-type: none"> • Difficulty gaining access via telephone. • Very positive feedback regarding clinical support and assessments. <p>Senior leaders had been trying to actively recruit administrative staff over the last six months and had begun to make changes to their telephone system.</p>

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.	15
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	3

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint received regarding appointment system and attitude of receptionist.	<ul style="list-style-type: none"> • Letter of response to patient. • Patient offered invitation to PPG meeting. • Equality and diversity training to be refreshed.
Patient information discussed at a multi-disciplinary meeting where the patients colleagues were present.	<ul style="list-style-type: none"> • Significant event raised • Discussed with those present at the meeting about disclosure of conflict of interests. • Aim to get patients employer details where possible.

Well-led

Rating: Requires Improvement.

At the last inspection in July 2019, we rated Well-led as requires improvement because:

- The practice did not have a vision, values and business strategy in place.
- There was not an active patient participation group (PPG).
- Arrangement for storage of paper patient records to prevent access by unauthorised people required needed to be reviewed.

The practice had made improvements, however we found new areas that require improvement:

- Whilst the practice had developed a vision and values statement, it was not clear how they would mark their progress against this.
- Oversight of governance was lacking and risks were not always identified.
- Where improvements or changes had occurred, progress was not always monitored.
- Statutory notifications were not always made in line with the Regulations.

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.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Leaders had begun implementing new ways of working and digital systems, however they did not always recognise the risk and challenges associated. For example, the transfer of data from paper files to digital or change of systems and processes.	

Vision and strategy

The practice had a clear vision, but it was not supported by a 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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	No

Explanation of any answers and additional evidence:
<ul style="list-style-type: none"> • Staff knew the practice had developed vision and values but were unclear of what they were. • Progress against delivery of the strategy and plans was not effectively monitored or reviewed.

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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Senior leaders did not have routine oversight of mandatory training. Post inspection we were provided with evidence that out of 37 staff, six did not have up to date equality and diversity training. 	

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

Source	Feedback
Staff interviews and questionnaires.	Positive feedback included themes of the practice having an open, friendly culture. Staff felt the practice hold patient interests and care in high regard. Whilst feedback was mostly positive, staff reported they would like to see communication improved especially by staff in administrative roles.

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.	No
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

- The practice had processes and procedures in place, however the oversight of these was often lacking.
- We saw examples of staff being allocated responsibilities, but if someone became unwell or took annual leave it was not always clear who would cover the workload.
- There was a lack of oversight of systems and processes relating to recruitment, training and ongoing staff development. For example, we requested evidence from the practice as part of our pre-inspection provider information request and again on the day, these were not provided for us until after the inspection site visit. Once reviewed we identified there were gaps in training records which demonstrated that oversight of what training was due and when was not effective.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:

Since the last inspection in July 2019, the practice acted on information to ensure safety of patient notes.

However, we found:

- Systems and processes that were embedded were not always effective or reviewed. This left the practice vulnerable to missed opportunities to assure themselves of good care. For example, there was no oversight of mandatory staff training to ensure it is completed in line with guidance. The practice also did not routinely review childhood immunisation or cervical screen data until the main data publication.
- Staff told us there were systems to support and manage performance, however these were not always documented or completed across all staff groups.
- The practice had developed some audit processes, including infection, prevention and control and response to safety alerts to reduce risk. However, this did not cover all high-risk areas such as controlled drugs prescribing and reviewing staff competence.

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Partial
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the time of inspection the practice was not routinely completing patient feedback surveys, however they had responded to concerns raised during a PPG meeting. This information was displayed in reception with actions, and where appropriate reasons why this could not be completed. The practice employed an infection prevention and control nurse. We saw how audits had been carried out to ensure patient safety and incidents were raised and resolved appropriately. Staff did not routinely work remotely, however we saw a GP partner did have access to systems remotely if required. 	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Partial

Explanation of any answers and additional evidence:

- We saw that clinical staff performed audits on their own care and checked outcomes for their own patients. However, this was not embedded at practice level.
- Clinical staff told us there was an open culture and they were able to have honest discussions with senior leaders. However, there were gaps in oversight of mandatory training and appraisals to ensure performance of staff was understood.
- We have received statutory notifications from the provider, but we saw examples where statutory notifications should have been made but hadn't. For example, where the police had been called to assist with an aggressive patient.

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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Explanation of any answers and additional evidence:

Since the last inspection in July 2019, the practice have developed a Patient Participation Group (PPG) and begun collating and responding to feedback. Senior leaders were aware of the challenges ahead to ensure the PPG meets the needs of the whole demographic.

Feedback from Patient Participation Group.

Feedback

- Provide a clean environment.
- Access was an ongoing problem which had been raised with the practice.
- Believe they had received good quality care when needed and health checks were completed.
- Felt assured by speaking to different health care professionals in the practice where appropriate, such as, the pharmacist for medicines concerns.
- Whilst they did feel communicated with, they were unsure if this resonated across the community.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Senior leaders encouraged an open culture including welcoming challenge from their peers. We saw that learning was shared with clinical staff and that discussions occurred. However non clinical staff were not consistently involved in conversation and developments. 	

Examples of continuous learning and improvement

- The nursing team developed a system folder for knowledge and information sharing within the practice.
- Relationships built with a Somali link worker had improved access for this community.
- Overhauled the long term condition recall system to improve consistency for patients.
- The practice had continued to engage with the Bristol, North Somerset, South Gloucestershire Integrated Care Board and participated in research projects presented.

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.
- **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.
- **%_o** = per thousand.