

Inspection Evidence Table

Abbey Medical Practice

(1-568446288)

Inspection Date: 27 November 2023

Date of data download: 26/10/2023

Overall rating: Good

Context

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the fifth decile (5 of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 83% White, 7% Asian, 6% Black, 4% Mixed, and 1% Other.

The age distribution of the practice population closely mirrors the local and national averages.

Safe

Rating: Good

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Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y

Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>One of the GP partners was the safeguarding lead for children and vulnerable adults. They were supported in the role by 2 safeguarding co-ordinators from the Primary Care Network (PCN). Staff were aware of who the safeguarding lead was and what to do if they needed advice on a safeguarding concern.</p> <p>The safeguarding lead GP was also the safeguarding lead for Northamptonshire and worked with the local Integrated Care Board (ICB) one day a week; they were trained to safeguarding level 4. The clinical staff and managers were trained to safeguarding level 3 and the non-clinical staff to level 2.</p> <p>The practice had a dedicated page for safeguarding on the internal website that contained information and education for staff on safeguarding matters. There were links to current guidance and local authority contacts. Alerts were used on the clinical system to identify patients and their families if there was a safeguarding concern. These alerts were visible to the Out of Hours service if a patient was seen out of practice working hours.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: October 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: February 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice was owned by an external company and the provider worked with the landlord to ensure risk assessments were carried out and identified actions were completed. The practice had oversight of risk assessments completed by the landlord.</p> <p>There were identified fire marshalls and fire evacuation drills were carried out every 6 months. The fire marshalls met after each drill to reflect and identify any learning to be shared with practice staff.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: Various dates in the previous 12 months	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence: Infection prevention and control (IPC) audits were carried out for different areas of the practices at throughout the year. A member of the nursing team was the lead nurse for IPC and all staff had received IPC training. Posters were displayed on the walls of the consultation and treatment rooms with handwashing advice. The practice was visibly clean and tidy.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence: The GPs had provided sepsis and spotting red flag symptoms training for the reception staff. There was guidance available for them to refer to in the reception office. We were informed a skills analysis tool was used to ensure the right number of staff with the right skills were employed. The practice had created a new admin support role for 2 staff members who were trained in different skills to support absences or times of peak demand. Reception staff were trained to carry out administrative tasks so they could rotate and have variety from answering the telephones. The practice informed us they used an external company to process new patient registrations which created approximately 50 hours per month to enable staff to undertake work in other areas.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence: Review of patient records in relation to the clinical searches identified that care records were generally managed in a way to protect patients. However,</p> <ul style="list-style-type: none"> We found for 1 patient a full examination that we would expect to see for the presenting symptoms in a child were not documented. Some patients had not received current blood monitoring. We noted that the practice had made attempts to contact the patients via text message. We were informed by the practice they restricted online ordering of prescriptions to 7 days, for patients who did not respond to attempts to contact them. 	

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) (01/07/2022 to 30/06/2023) (NHSBSA)	0.98	0.93	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2022 to 30/06/2023) (NHSBSA)	6.5%	7.4%	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 (01/01/2023 to 30/06/2023) (NHSBSA)	4.74	5.14	5.24	No statistical variation

Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	130.5‰	134.6‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.49	0.55	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	7.9‰	7.6‰	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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	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

Explanation of any answers and additional evidence,
 We carried out a remote search of the clinical record system and reviewed 5 patients who had received a medicine review in the 3 months prior to the inspection. We identified that care records were managed in a way to protect patients.

The monitoring of patients who were prescribed high-risk medicines was managed well. A remote review of the patient record system showed that patients were receiving blood monitoring prior to medicines being prescribed.

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:	155
Number of events that required action:	155
Explanation of any answers and additional evidence: Significant events or learning events were managed by the quality manager. The practice staff were encouraged to report positive events to learn from in addition to any mistakes or near misses. The quality manager met with the lead GP to review all events; learning was discussed and shared at team meetings. The practice informed us that whilst they had a high number of significant events, most of these were learning events and they were revising their process regarding these.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Actions were not taken as directed from a letter received about a patient who had been seen in secondary care.	The event was reviewed and investigated. The staff member who processed the letter reflected on their actions. Staff were reminded to double check communications and ensure they are sent to the correct practice staff for actions to be completed.
The expiry dates had not been checked on the anaphylaxis kits held in the treatment rooms.	The error was picked up on an audit of processes. The task of checking the anaphylaxis kits was added to the emergency medicines and equipment check lists.

Safety alerts	Y/N/Partial
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There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence: Safety alerts were received into the practice via email and the system for recording and acting on them was managed by the lead GP for prescribing and the clinical pharmacist.</p> <p>Safety alerts were shared and discussed with staff at clinical meetings.</p> <p>We carried out a remote review of the clinical record system and found appropriate actions had been taken in response to safety alerts received. For example, we reviewed 5 patients who were prescribed citalopram or escitalopram, a treatment for depression that may cause an abnormal heart rhythm, the risk of which increases with age. We found there was documentation in the patients' clinical record that the risk of side effects had been discussed with the patients.</p>	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

Patients' needs were usually assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. However, we found some gaps where guidance had not been followed.

	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.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y

The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We carried out a remote review of the clinical system and found there were 44 out of 2661 patients diagnosed with asthma who had been prescribed more than 12 short acting inhalers in the previous 12 months. We reviewed 3 patients and found they had all been prescribed additional preventative medicine to reduce the risk of an exacerbation on their asthma and had received an annual review. However, it was not documented that the high use of short acting inhalers had been discussed or the dose of the preventative medicine increased. We discussed this with the lead GP who advised further education would be provided to the clinicians to check the use of short acting inhalers at asthma reviews.</p> <p>Our remote review of the clinical record system found there were 16 patients who had potentially a missed diagnosis of diabetes. We reviewed 5 of these patients and found 2 of these had not had a pre-diabetes code added to their patient record and 1 patient had a pre-diabetes code added but had not received any follow up. Further monitoring, education, treatment or screening were not carried out. We were advised by the lead GP that all 16 patients would be reviewed and clinicians advised to use the correct codes when reviewing blood test results.</p>	

Effective care for the practice population

Findings

- 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.
- Patients who were recently bereaved were directed to the practice website for support information. A care coordinator contacted them after 6 weeks to see if further support was required.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.
- Care plans were in place for patients with complex needs and were regularly reviewed by the nurse practitioner and care coordinators.

Management of people with long term conditions

Findings

Our remote review of the clinical record system found,

- There were 147 patients diagnosed with asthma who required high dose steroid treatment for asthma exacerbations. We reviewed 3 of these patients and found they were all appropriately assessed at the

time of prescribing the steroid treatment. However, there were 2 patients that were not followed up within 48 hours as recommended by current guidance or had their regular asthma medicines increased to prevent further exacerbations. The lead GP advised us that an education meeting had been planned to update clinicians on the correct processes and codes to use when treating patients with worsening asthma symptoms.

- There were 5 patients out of 978 diagnosed with hypothyroidism who did not have up to date monitoring which meant they may not be on the correct dose of medicine to treat the condition. We reviewed 3 of these patients and found the practice had made many attempts to contact the patients to attend. Online access to repeat prescription requests had been stopped for these patients to encourage them to contact the practice. The provider had not taken further steps to encourage engagement such as a reduction in the amount of medicine prescribed.
- There were 164 patients diagnosed with diabetic retinopathy who had a high HbA1c level (HbA1c is a measure of blood sugar control). We reviewed 3 of these patients and found 2 had not received a blood test or blood pressure check for over 3 years. However, we did note the practice had made many attempts to contact the patients to invite them for a review.

Patients with long-term conditions were offered an 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.

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)	211	228	92.5%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	236	256	92.2%	Met 90% minimum
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)	236	256	92.2%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	235	256	91.8%	Met 90% minimum

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	254	283	89.8%	Below 90% minimum
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

We were informed if children were not brought to the practice for immunisations, the parents or guardians were contacted by telephone and letter. Information was shared with the health visiting team if children were not brought in.

Educational leaflets were available on the benefits of immunisations.

Flexible appointment booking was offered outside of the usual childhood immunisation clinics.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	67.3%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	69.2%	N/A	70.3%	N/A
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). (3/31/2023 to 3/31/2023) (UKHSA)	70.4%	N/A	80.0%	Below 80% target
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)	60.7%	56.5%	54.9%	No statistical variation

Any additional evidence or comments

The practice was aware they were below the 80% target for the uptake of cervical screening set by the UK Health and Security Agency and had put measures in place to address this.

Reception staff were encouraged to raise awareness of cervical screening when eligible patients who had not attended for screening contacted the practice. Flags were placed on patient clinical records to identify who was overdue screening so they could be opportunistically spoken with.

The practice used text messages and telephone calls to remind patients to book an appointment for screening.. Have made evening and weekend appointments available.

The practice had run specific clinics for Asian patients who were sometimes reluctant to attend.

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

Any additional evidence or comments

The practice had an audit plan in place that covered clinical and administrative processes in the practice.

Searches of the patient clinical system were made every month to ensure patient care and monitoring was completed in line with current guidelines.

The GP registrars were involved in undertaking clinical audits as part of their training. One of the GP registrars had undertaken an audit of patients with high cholesterol. As a result of the audit they had developed a patient information leaflet on how to manage cholesterol levels. This was presented at the clinical meeting and a reaudit was planned to demonstrate any improvements.

The practice were consulted on and shared their practises with the local Integrated Care Board on high numbers of referrals to local pharmacies to reduce the demand on GP appointments.

Practice was working with the Primary Care Network on health inequality projects. For example,

- They found patients with a higher body mass index (BMI) were less likely to have had cervical screening completed, so they were exploring what barriers these patients may face.
- They found Afro-Caribbean patients aged over 45 years were less likely to have screening for prostate cancer. They were encouraging this group of patients them to book for this test due to being at higher risk.

The nursing team carried out infection prevention and control audits and cervical screening quality of sample audits.

Call monitoring audits were carried out by the quality manager to ensure staff were treating patients well when they spoke with them on the telephone.

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
<p>Explanation of any answers and additional evidence: The practice had identified mandatory training for staff and provided this either online or face to face. All staff received an annual appraisal where performance and developmental needs were reviewed. The advanced nurse practitioners had weekly clinical supervision meetings with a GP.</p>	

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
<p>Explanation of any answers and additional evidence: Multi-disciplinary team meetings were held monthly with community staff to agree the care of patients with complex needs. Special notes were used on the patient clinical record system to relay pertinent information about individual patient's care to community teams.</p>	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y

Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a cancer care coordinator who contacted patients when they received a new cancer diagnosis. They advised of support information for the patients to deal with both the diagnosis and social support such as assistance with claiming any available benefits and insurance for travel. The cancer care co-ordinator worked alongside the social prescribers to direct patients to relevant support organisations. There were links to health information advice on the practice website. Referrals were available to external organisations for healthy lifestyle support. We were informed by the practice that they received positive feedback from patients who had been helped by the cancer care coordinator.</p>	

Consent to care and treatment

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

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

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y

The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice worked as part of a Primary Care Network (PCN). PCNs are groups of GP practices collaborating with community, mental health, social care, pharmacy, hospital, and voluntary services in their areas to provide local services.</p> <p>Dedicated parking spaces and access enabled toilets were available for patients with a disability. There was level access and automatic doors at the entrance. Baby changing facilities and a private area for breast feeding were available.</p> <p>Treatment and consultation rooms were available on the ground floor. Lifts were available to all levels. Some staff members had been trained to use British Sign Language to support patients who were hard of hearing.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
<p>Appointments were available throughout these times.</p> <p>Home visits were available for housebound patients.</p> <p>Extended access was provided locally by The Wellingborough GP Enhanced Access service, where appointments are available from 6.30pm to 8pm Monday to Friday and from 8am to 12pm on weekends and bank holidays.</p> <p>The practice provided some evening and weekend pre-bookable appointments according to demand.</p>	

Further information about how the practice is responding to the needs of their population
<p>Patients had a named GP who supported them in whatever setting they lived.</p> <p>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.</p> <p>The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.</p> <p>Appointments were available outside of school hours for children.</p> <p>All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.</p> <p>The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers</p>

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 had a care co-ordinator for veterans who provided support to meet their needs.
 The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence: Patients could book appointments by telephone or via online services for some practice nurse appointments. Reception staff were trained care navigators so they could direct patients to the most appropriate health care professional to meet their needs. There were protected appointments for patients that had accessed healthcare via the NHS 111 service. Appointments were available either face to face, online or by telephone. Flexible appointment booking and longer appointments were available for patients with multiple conditions or complex needs.</p>	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	83.5%	N/A	49.6%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	75.8%	50.8%	54.4%	Tending towards variation (positive)

The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	63.3%	50.1%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	87.1%	71.4%	72.0%	Variation (positive)

Any additional evidence or comments

The practice had made changes to how they worked to improve access and appointment availability and increase patient satisfaction.

One of the GPs and a member of the administration team had developed a system to monitor and manage demand and capacity. The system highlighted if they were not meeting the demand for same day appointments.

Capacity was identified in advance by analysing demand in the past. For example, more appointments were required on Mondays and Fridays. They also looked at how many same day and routine appointments were needed and allocated a certain number of appointments to GPs for follow up care.

The staff rotas were discussed at the weekly GP partners meeting and the practice used regular locum GPs to fill any gaps in the rota. We were informed the GP partners were willing to work additional hours to ensure sufficient appointments were available. The practice planned appointment availability 2 to 3 months in advance. The practice had changed their telephone system to a cloud based service. This enabled them to monitor the amount of calls they received and the amount they did not answer. They could view how many calls were incoming and adjust staff accordingly to answer calls at peak times. Patients had the option of having a call back when they had reached their place at the top of the queue rather than wait on the telephone.

A floater GP was based in the reception office to answer any immediate queries.

Regular audits of the telephone system and the clinical record system were carried out to monitor performance.

A telephone wallboard was situated in the reception office to monitor incoming calls and staff were allocated to answer the telephones at peak times in the day, for example, 8am and 1.30pm.

We were informed the average wait time on the telephone was 3 mins and 33 seconds.

Results from the National GP Patient Survey demonstrated there had been an upward trend in patient satisfaction since 2022 regarding access and appointment booking for all 4 indicators to above local and national averages in 2023. For example,

- 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 was 58.5% in 2022.
- The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment was 65% in 2022.
- The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times was 63% in 2022.
- The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered was 76% in 2022.

The practice informed us patients who provided compliments were contacted to understand the specifics regarding the positive feedback to enable further enhancements to the service.

The practice had the facilities for patients with long term conditions to record information about their condition and observations, for example, of their weight, height and blood pressure prior to their long term condition review. This meant less time was needed with a clinician and more appointment availability was created.

Source	Feedback
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NHS.uk website (formerly NHS Choices)	<p>There were 24 positive reviews of the practice left on the NHS.UK website in the 12 months prior to the inspection. Staff were described as helpful and polite. The reception team in particular received many positive comments on their willingness to help and their attitude when answering the telephone and patient queries. Patients commented on how the appointment system had improved and they were happy with the availability of appointments.</p> <p>There was 1 negative comment regarding the length of time to book an appointment.</p>
CQC website Give Feedback on Care	<p>We received feedback from 50 patients with 44 of them entirely positive about the practice. Staff were described as efficient, friendly and helpful. Patients stated they liked the new telephone system and that staff were flexible in helping them to book a suitable appointment. They felt the practice had listened to their patients to make changes and they liked the text reminders so they did not miss their appointments. There were many positive comments regarding the care and support received from all staff levels.</p> <p>There were 2 patients who gave mixed feedback; 1 regarding care received from a GP but they were happy with the nursing staff and 1 regarding administrative processes when registering with the practice. They were however satisfied with the help they received.</p> <p>There were 4 patients who gave negative feedback regarding the care they received, referrals to other services and some administrative processes.</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.	35
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example of learning from complaints.

Complaint	Specific action taken
Complaint regarding treatment and a potential missed injection.	<p>The complaint was categorised as an expression of dissatisfaction. Information was provided on the treatment and intervals between injections.</p> <p>Information leaflets were made available to send to patients electronically regarding their treatment.</p>

Well-led

Rating: Good

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: Leaders were aware of the challenges faced both locally and within the wider NHS. They had taken positive action to provide sufficient appointments to meet patient demand. The practice worked with other local practices within a Primary Care Network (PCN) to deliver services locally. The practice trained GP registrars and many were supported into salaried GP roles when they had completed their training.	

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: There were weekly GP partner meetings where progress and performance was discussed. The provider had a mission statement that was displayed in the practice and on the practice website.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff were supported with annual appraisals and 121 meetings. Lead members of staff were identified and there was a staffing structure in place that allowed for staff development and progression.</p> <p>The practice carried out staff surveys. The most recent survey showed staff were generally happy working at the practice and with their roles.</p> <p>The practice used an external company for support with human resources policies and procedures.</p> <p>There was a staff wellbeing coordinator who promoted social events and activities to boost staff morale.</p>	

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

Source	Feedback
Staff interviews and questionnaires	<p>Feedback from staff was positive about working in the practice. They felt there was good teamwork and the GPs and practice management were supportive. Staff particularly were happy with the practice manager and how they were knowledgeable and experienced running the practice.</p> <p>Some staff felt it was challenging dealing with patients who were not satisfied with the service and there could be pressure when answering the telephones.</p>

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:	

There were policies and procedures in place to govern activity in the practice. All staff had access to these on the practice internal website.
All staff had a job description that outlined their roles and responsibilities.

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

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: The practice used the Quality and Outcomes Framework (QOF) to manage performance. Data from the telephone system and clinical record system was monitored and used to assess capacity and demand.	

Governance and oversight of remote services

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

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence: The practice had carried out a patient survey. They sent the survey to 19,000 patients via an online platform and had received 12,000 responses. At the time of the inspection the practice had collated and analysed the responses and planned to share them with the Patient Participation Group. The practice informed us that 17.5% of the respondents found that the service was outstanding.</p>	

Feedback from Patient Participation Group (PPG).

Feedback
<p>Feedback from the PPG also known as the Patient Action Group was positive. Meetings took place every 2 months and were attended by the practice manager. A GP attended every other meeting.</p> <p>The practice provided feedback to the group on how they were performing and any future plans. The group were consulted on any changes the practice planned to make. They were given updates on the new telephony system and appointment booking.</p>

Continuous improvement and innovation

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

	Y/N/Partial

There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice used significant events and complaints to identify areas of learning and improvement. Regular team meetings were in place to share learning.	

Examples of continuous learning and improvement

The lead GP for safeguarding worked with the local Integrated Care Board one day a week to develop safeguarding processes and policies. They had developed an internal website page for collating all safeguarding information and links to external agencies and current guidance. This page was shared with other practices locally.

Educational meetings were held once a month where various topics were discussed including, clinical audits and current clinical guidance.

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.