

Care Quality Commission

Inspection Evidence Table

Dr Poolo's Surgery - Rush Green Medical Centre (1-542271050)

Inspection date: 19 and 31 October 2022

Date of data download: 18 October 2022

Overall rating: Good

We carried out a rated full inspection of this provider on 30 September 2021. This inspection was the six-month follow up inspection as a result of the practice having been placed into special measures at the inspection prior to the September 2021 inspection. At the September 2021 inspection, we found a number of issues with regards to the provision of services at the practice including missing policies on the practice shared drive which was disorganised, inconsistent monitoring of cervical screening results, lack of detail contained within practice meeting minutes, staff not undertaking basic life support training annually with no risk assessment completed by the practice to explain why this was the case and no system to ensure actions from meetings were consistently followed up.

At this inspection held on the 19 and 31 October 2022, we found the practice had acted on the issues identified at the September 2021 inspection. We found the issues identified in the above paragraph had been addressed and the practice were able to evidence what systems they put in place to address the issues identified.

As a result of the improvements made by the practice, the practice is now rated as good overall and in all key questions.

Safe

Rating: Good

We carried out a rated comprehensive inspection of this provider on 30 September 2021. At the September 2021 inspection, we found a number of issues relating to the provision of safe care at the practice which included inconsistent monitoring of cervical screening results and the usage of blank prescriptions held, no induction checklist for clinical staff, no locum handbook for locum GPs to refer to and there was no risk assessment completed to support the practice's decision that basic life support training would not be completed annually, as per Resuscitation Council UK guidelines. These issues led to the practice being rated requires improvement overall and for this key question.

At this inspection held on the 19 and 31 October 2022, we found the practice had acted on the issues identified at the September 2021 inspection. We found monitoring of cervical screening results had been improved and systems put in place to monitor results received, and a checklist for new staff joining including clinical staff. Staff training for basic life support had been undertaken by all staff.

As a result of the improvements made by the practice, the practice is now rated as good for the provision of safe care.

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
Explanation of any answers and additional evidence:	
The practice had adult safeguarding and child safeguarding policies in place, which identified the practice's safeguarding lead and contained details of local authority or other external contacts to whom safeguarding concerns should be reported. The practice continued to have a separate 'Practice Leads' document displayed throughout the practice for staff to know who to contact, and there were local authority contact details displayed in consultation rooms and on the practice shared drive on the computer system.	
We checked a sample of records on the clinical system for patients on the adult and child safeguarding registers and found they had a pop-up alert attached to their record to notify staff they are vulnerable	

Safeguarding	Y/N/Partial
and there was information recorded in the summary record as to why patients were at risk. The Out of Hours service was able to access relevant safeguarding information about patients through the practice's clinical system.	
Guidance from the local authority was used to ensure that the practice's safeguarding registers were up to date and accurate. We reviewed minutes of meetings of internal practice meetings, which referred to communication with relevant external healthcare professionals which demonstrated that patients at risk were monitored and discussed appropriately.	
We reviewed staff files for three members of staff members and found appropriate DBS checks had been carried out by the practice.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence:	
There was a recruitment policy in place which set out what checks would be carried out when employing new staff. The practice had a checklist for recruitment, to ensure that all the required documentation was obtained and checks completed for new starters. We reviewed staff files for three staff members (including one recently recruited) and found appropriate recruitment checks had been carried out. A record of staff immunisations was also kept.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 17 May 2022	P
There was a fire procedure.	Y
Date of fire risk assessment: 17 May 2022 Actions from fire risk assessment were identified and completed.	P
Explanation of any answers and additional evidence:	
At our previous inspection of the practice held in September 2021, the practice did not have a clear understanding of the need for risk assessments for any storage of hazardous substances (COSHH), and were unable to provide COSHH risk assessments for products which would be commonly used at a GP Practice such as cleaning products or hand sanitiser. At the site visit for this inspection undertaken, on 19 and 31 October 2022, we found the practice had conducted appropriate COSHH risk assessments for commonly used products within the practice such as hand sanitiser and products for cleaning.	
The practice had a fire safety policy and procedure, and there were named fire marshals and fire assembly point were recorded on fire safety posters displayed in the premises.	

A fire risk assessment and health and safety risk assessment had been carried out by an external safety company in May 2022. We noted that there were a few minor remedial actions to be completed on both risk assessments, but we did not see evidence that actions to reduce the risk within the defined time period specified within these reports had been completed.

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. Date of last infection prevention and control audit: 17 May 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
When we checked a sample of staff training records, we saw staff had completed up to date infection control training.	
An infection control audit/risk assessment had been carried out by an external safety company on 17 May 2022.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence:	
There was a staff induction checklist for all new staff which not specific to administrative or clinical staff.	
Staff training records we checked had evidence that staff had completed up to date basic life support training and fire safety training.	

The practice had a mandatory staff training policy which set out the required training for all staff. Monitoring of completion of mandatory training was undertaken by both the business and practice managers using an online portal where they had oversight of training undertaken by staff working at the practice.

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. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
<p>There was a system in place to manage test results, which involved the GPs checking the inbox on the clinical system every day the practice was open. When we reviewed the test results inbox on the practice's clinical system at this inspection, we found test results were being viewed and actioned in a timely manner, with no outstanding or overdue results.</p> <p>At our September 2021 inspection, we noted that cervical screening results coming into the practice were tracked by way of a handwritten book that was kept by the practice nurse. At this time, the inspection team found this system was not effective, as we identified gaps in the handwritten book where no result had been recorded as being received, despite the clinical system records for relevant patients having been updated with results of the most recent screening.</p> <p>At this inspection the practice had revised their system to monitor cervical screening results, with all results being entered on the clinical system when received, ensuring that patients who required further testing were contacted in a timely manner.</p>	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.91	0.62	0.82	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). (01/07/2021 to 30/06/2022) (NHSBSA)	8.8%	9.3%	8.5%	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 (01/01/2022 to 30/06/2022) (NHSBSA)	6.13	5.76	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	55.5‰	64.4‰	128.0‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	1.01	0.46	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	5.1‰	5.4‰	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

Medicines management	Y/N/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.	n/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>Prescriptions were stored securely within the practice and there were controls in place to monitor the distribution of blank prescriptions to staff.</p> <p>We asked to review a sample of Patient Group Directions (PGDs) authorising the practice nurse's administration of medicines to patients (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) and found that the sample reviewed were signed by both the practice nurse and provider.</p> <p>We viewed a selection of patient records on the provider's clinical records system and did not identify any concerns in relation to medication reviews. The medication reviews we looked at were clearly documented to show structured clinical reviews of patients' medicines had been undertaken. Similarly, we found the provider had a system in place to monitor patients on medicines requiring monitoring to ensure they would be called for blood tests as and when needed.</p>	

Medicines management	Y/N/Partial
The practice had medicines and equipment for use in an emergency, which were checked regularly by the practice nurse.	

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:	2
Number of events that required action:	2
Explanation of any answers and additional evidence:	
<p>At our last inspection held in September 2021 we identified that despite the practice having a significant events policy which set out the process for reporting and acting upon significant events, this was not being adhered to by all members of staff. At this inspection held on the 19 and 31 October 2022, we found that the significant events policy was being followed and adhered to by all members of staff.</p> <p>The inspection team asked the practice to provide us with copies of any significant events that had occurred over the last 12 months, so that we able to assure ourselves that the practice policy was being followed consistently by staff. The practice provided us with two significant event forms to review, which (alongside a review of meeting minutes for the period the significant events occurred) evidenced compliance by staff with the significant events policy.</p>	

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

Event	Specific action taken
Patient unable to get an appointment within specified timeframe for suspected condition.	Patient contacted practice who followed up referral with local hospital. This enabled patient to obtain an appointment shortly after referral timeframe. Practice staff discussed this event at the practice meeting following the event, identifying what went well and where further training for staff would be beneficial.

Safety alerts	Y/N/Partial
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There was a system for recording and acting on safety alerts. ¹	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We checked on the practice's clinical system to see if there was adherence to specific safety alerts. We also saw that patients of childbearing age prescribed medicines with teratogenic potential (the potential to increase the risk of birth defects and development disorders when taken during pregnancy) were fully informed of the risks and managed appropriately.	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
<p>At our inspection of this provider in March 2021, we saw examples where patients were identified as requiring onward referrals or follow-up and intervention from a GP, but there was no evidence that these referrals or follow-ups had taken place. At this inspection held on 19 and 31 October 2022, our review of patient records did not identify any similar concerns.</p> <p>At this inspection, our review of patient records did not identify concerns in relation to the general management of patients with long-term conditions. We saw the practice had carried out audits looking at management and reviews of patients with conditions including epilepsy, chronic kidney disease, diabetes, asthma and COPD. The practice continued with its appointment system of reserving two slots per session for each clinician specifically for follow-up of patients with long-term conditions.</p>	

We reviewed a sample of care plan reviews and found they were well documented, had been completed with the patients' involvement, and contained evidence of discussion of patients' current medical conditions and their wishes.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long term medicines.
- 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.

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)	33	41	80.5%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	47	54	87.0%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	48	54	88.9%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	46	54	85.2%	Below 90% minimum
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)	38	56	67.9%	Below 80% uptake

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

Any additional evidence or comments

The practice's childhood immunisation uptake rates for April 2020 to March 2021 were below the World Health Organisation (WHO) targets for four out of five of the above indicators. This was an improvement on the uptake rates identified at the last inspection of the practice held in September 2021. Prior to this inspection, we asked the practice to provide the inspection team with the most recent figures for childhood update, which were provided, however these figures did not specify the period they referred to.

The practice nurse told us they were aware of the uptake rate of childhood vaccines at the practice and explained the process of contacting parents of children to encourage them to attend for recommended immunisations. We were told the practice nurse would follow up with patients by telephone who do not attend and will offer for the lead GP to discuss their reluctance to attend with them and explain why it is important. We saw alerts were placed on patient records so staff could approach patients opportunistically to invite them to attend.

Appointments were available every weekday, with early morning appointments on Wednesdays from 7.30am so patients could attend before work or school. The practice nurse explained they are not available afternoons or evenings for appointments, but that the lead GP could administer immunisations if patients could only attend later appointments.

The practice had a fairly small population list and therefore if a few families chose not to attend this would impact upon the uptake figures.

Cancer Indicators	Practice	SICBL 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: 31/03/2022) (UK Health and Security Agency)	72.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	67.0%	54.8%	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)	61.1%	58.1%	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)	53.3%	53.3%	55.4%	No statistical variation

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.

Any additional evidence or comments

The practice's uptake for cervical screening as of 31 March 2022 was 72.5%, which was below the Public Health England 80% coverage target for the national screening programme but an improvement on the practice achievement score of 67% identified at our September 2021 inspection. Prior to this inspection, the practice provided the inspection team with the most recent figures for cervical screening, which showed an unverified figure of 79% uptake for women aged between 25 and 49; and 88% uptake for women aged between 50 and 64 over a 24 month period.

Appointments were available Monday to Friday in the mornings. Patients could also attend Saturday clinics for cervical screening appointments through the local primary care network.

The practice telephoned patients to encourage them to attend for their screening appointment, by explaining the process to them, confirming they will be covered, and measures put in place to protect their dignity. In addition, discussions with patients regarding how to minimise discomfort were undertaken and explanations given why it is important to have the screening.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

The practice undertook an audit which focused on the prescribing of controlled drugs. The audit was part of an overall audit which looked at prescribing of high-risk medicines to ensure the practice was prescribing safely and to national guidelines. This audit focusing on prescribing of controlled drugs was undertaken over six months. Analysis of each prescribed controlled drug was undertaken by the GP partners and salaried GP, with each GP responsible for prescribing these types of medication providing an explanation why these types of medicines were being prescribed.

The results of the audit were discussed at a practice clinical meeting where it was noted that changes to prescribing habits and limiting prescriptions for these types of medication to seven days was effective to minimise dependence and abuse of these types of medicines.

These changes allowed the practice to implement internal safety netting protocols rule to maintain patient safety whilst patients are taking these types of medication.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y

Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw clinicians had completed role-specific training, for example long-term condition reviews, immunisations and cervical screening. Staff told us they were given time to complete training.</p> <p>The practice had an induction checklist in place for new staff. Following a recent significant event which occurred at the practice, we were informed that all clinical staff involved in referring patients to secondary care would be trained on how to do this as part of their induction.</p> <p>We were told staff appraisals were completed annually. We checked a sample of appraisals and saw they had been completed within the last year and had specific objectives identified for the staff member.</p> <p>We viewed three staff files and found that they contained certificates to indicate the skills, knowledge and experience to deliver effective care, support and treatment (where relevant).</p>	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

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

Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	
<p>The practice continued to participate in social prescribing (social prescribing), enabling GPs and other healthcare professionals to refer people to services in their community, where these services (and what they could provide) were thought to be more beneficial to the patient than medicines.</p> <p>The practice had a social prescriber through its primary care network to whom staff could directly refer patients. We heard from one of the clinicians about referrals to the social prescriber to assist a patient's with housing issues.</p> <p>Care plans that the inspection team reviewed at this inspection were found to be well documented, completed with the patients' involvement, and contained evidence of discussion of patients' current medical conditions and their wishes.</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. ¹	Y
Explanation of any answers and additional evidence	
<p>We saw examples in patient records where clinicians had recorded patient consent, for example for regular administration of medicines and for childhood immunisations.</p> <p>We reviewed a sample of DNACPR decisions and did not identify any concerns around consent.</p>	

Well-led

Rating: Good

We carried out a rated comprehensive inspection of this provider on 30 September 2021. At the September 2021 inspection, we found a number of issues with regards to the provision of well-led services at the practice which included missing policies on the practice shared drive which was disorganised, lack of detail contained within practice meeting minutes and formal system to ensure actions from meetings were consistently followed up and finally, policies and procedures were not all version controlled or had a next review date noted on the policy. These issues led to the practice being rated requires improvement overall and for this key question.

At this inspection held on the 19 and 31 October 2022, we found the practice had acted on the issues identified at the September 2021 inspection. We found policies on the practice shared drive had been organised and were easily accessible, minutes from practice meetings were detailed and specified who was responsible for following up on actions and policies and procedures had review dates detailed on the front of each document.

As a result of the improvements made by the practice, the practice is now rated as good for the provision of well-led services.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
Staff reported that leaders were visible and told us they felt confident approaching leaders with any issues or concerns.	
Leaders had taken account of CQC's findings from the previous rated inspection in September 2021 and put systems and processes in place to address the risks. This was evidenced through the creation of documents relating to COSHH and the implementation of systematic monitoring of cervical screening results. However, whilst there was a system to monitor blank prescriptions held at the practice, this was an area where the practice could make some minor improvements.	
Since our last inspection the provider had acquired a new partner. The new partner was familiar with the practice and patients having previously worked as a salaried GP at the practice. During the inspection, the senior partner was able to discuss with the inspection team plans for the future of the practice including the recruitment of a permanent female GP.	

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:	
<p>The practice had a formulated vision and mission statement which outlined that ‘patients come first’ and that the aim is to provide professional, accessible, and high-quality care. We were told that this vision and mission statement had been created by the lead partner but had not been developed in collaboration with staff or patients.</p> <p>Staff we spoke with told us the practice’s core values and mission statement was to provide high quality patient care and that patients come first.</p>	

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.	N
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<p>There were systems within the practice to deal with occurrences of displays of behavior not in line with the vision and values of the practice</p> <p>We were told by management staff that the senior partner would ultimately be responsible for acting upon and managing staff if there were issues with behavior or performance.</p>	

The practice had a whistleblowing policy in place, which stated that staff could contact their local Freedom to Speak Up Guardian to report concerns. We noted from the separate functional leads document that the primary lead for the practice speak up guardian was on long-term leave from the practice and there was no replacement named for this role.

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

Source	Feedback
Staff member	All staff are friendly. Staff encouraged to talk about concerns or ask questions, which motivates staff to work better.

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:	
Staff were aware of their roles and responsibilities and the governance arrangements for the practice, including the practice leads for areas including safeguarding, infection control, and complaints.	
Policies and procedures were stored on the shared drive of the practice's computer system. We viewed a selection of policies and found these to have the latest version and the date that version had been reviewed/updated on the first page of the policy.	
Practice and clinical staff meeting minutes we viewed summarised items discussed. Where follow-up actions were identified, the meeting minutes noted who was responsible for the follow-up action.	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y

Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>At the September 2021 inspection, the practice had recently introduced systems to manage and proactively monitor perceived clinical and administrative risk. At this time, we found that the service had not fully embedded the new systems as we identified some gaps the monitoring and management of systems.</p> <p>At this inspection dated 19 and 31 October 2022, we found that these systems had been embedded within the practice. We found systems in place to monitor and manage cervical screening results, to authorise prescribed medicines and risk assessments in place relating to the control of substances hazardous to health (COSHH) held at the practice. The exception to this was the inconsistent monitoring of blank prescriptions.</p> <p>The practice had a business continuity plan in place and buddy arrangements with a neighboring practice in the event of a major incident.</p>	

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:	
<p>The practice used information held internally and information from external sources to monitor performance of the practice and to ensure services provided to patients allowed them to receive quality care.</p> <p>The audit and quality improvement activity viewed as part of this inspection, were carried out to review and improve the practice's clinical performance in certain areas, for example medication reviews, high-risk medicines, and diagnosis and coding of certain long-term conditions. The practice had effective systems in place to monitor incoming safety alerts and outgoing urgent referrals.</p> <p>Clinical record keeping at the practice showed clear documentation and effective use of clinical templates.</p>	

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
Explanation of any answers and additional evidence:	
<p>We saw minutes of Patient Participation Group (PPG) meeting which took place in July 2022 and a combined PPG meeting minutes of GP practices in the local primary care network (which the practice is part of) dated June 2022. Both sets of meeting minutes demonstrated that PPG members were able to raise concerns and suggestions, and that the practice provided information and updates to them. We were told the practice welcomes complaints and patient feedback, as it is used to improve services.</p> <p>We saw the practice attended regular meetings with its primary care network to discuss local services and population needs.</p> <p>The most recent National GP survey showed the practice to be 10% higher than the national average and 16% higher than practices in their local care board (ICB) in relation to patients describing their experience overall experience of this GP practice as good.</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:	
<p>There was a focus on continuous learning at the practice and using the resources available to deliver quality care. This was seen through the work conducted by the practice using the data generated by QOF and use of shared primary care shared staff to deliver better outcomes for patients, through timely interventions in their care.</p> <p>There was evidence of learning shared widely within the practice and was seen through viewing meeting minutes from clinical staff and all staff meetings.</p> <p>The senior partner was able to discuss with the inspection team his continued clinical development evidencing this through an award from the Indian School of Psychology (InSPA) for services in the field of psychology and health services.</p>	

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 SICBL 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 SICBL 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.