

Inspection Evidence Table

Yeading Medical Centre

(1-552485760)

Inspection Date: 6-9 June 2023

Date of data download: 06/06/2023

Overall rating: Good

Context

The practice delivers primary care services to a patient population of around 7000 living in Ealing and Hillingdon in North West London. Information published by the Health Security Agency shows that deprivation within the practice population group is in the third lowest decile (3 of 10). The lower the decile, the more deprived the practice population is relative to others. Rates of obesity, hypertension and diabetes are relatively high. The practice population is ethnically diverse and the age distribution of the practice population is younger than the national average, with more patients aged under 18 and working age adults and fewer patients aged 65 or over.

Following our previous rated inspection in March 2022, the practice was rated requires improvement overall. At that time, we found shortcomings in the management of risk. For example: patients prescribed certain medicines were not always monitored appropriately; patient safety alerts were not being implemented and the management of long-term conditions was inconsistent. We also found that 'Do not attempt cardiopulmonary resuscitation' records were not always complete or easy to follow. More generally, quality improvement was not embedded into everyday practice and the practice had experienced management instability which had a negative impact on the wider team.

Safe

Rating: Good

Safety systems and processes

The practice had 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 and social workers to protect adults and children at risk of significant harm. | Y |
| Explanation of any answers and additional evidence: The lead GP was the safeguarding lead for children and adults and had oversight of safeguarding arrangements within the practice. They described a recent example when they had taken action and liaised with external agencies to protect a patient at risk of abuse. The case had resulted in safeguarding action being taken by the relevant authorities. | |

| 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: 15/05/2023 | Y |
| There was a fire procedure. | Y |
| Date of fire risk assessment: 15/05/2023 | Y |
| Actions from fire risk assessment were identified and completed. | Y |

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: 03/03/2023 | 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 |

Risks to patients**There were 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. | Partial |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There were enough staff to provide appointments. • The lead GP had taken on aspects of practice management in addition to their responsibilities for clinical oversight and their own clinical sessions. The lead GP acknowledged they had a large workload at the time of the inspection but told us this was their choice for the time being. In the longer term, the practice had plans to recruit an additional partner and more managerial support. | |

Information to deliver safe care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Y |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Y |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Y |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Y |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Y |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | N/A |

Appropriate and safe use of medicines

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

| 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) | 1.01 | 0.68 | 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) | 6.8% | 7.6% | 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) | 5.58 | 5.41 | 5.24 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA) | 74.4‰ | 57.8‰ | 129.5‰ | 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) | 0.25 | 0.42 | 0.54 | Tending to variation (positive) |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA) | 3.5‰ | 4.8‰ | 6.8‰ | Tending to variation (positive) |

| 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. | Partial |
| 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 |
| <p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> We carried out a standardised search of the practice patient records system to review its management of medicines and repeat prescribing. These searches showed that the practice was managing most of the medicines we looked at in line with guidelines. The practice had markedly improved its management of medicines which require ongoing monitoring since our previous inspection. We found that the practice was actively carrying out medication reviews. We reviewed a sample of 5 recent medication reviews and found that most (4) of the reviews were clearly documented. In one case, there was insufficient information recorded to show which medicines had been reviewed and the outcome of the review. We raised this with the practice who told us they would monitor the consistency of recording across the clinical team. | |

- The practice had contracted with an external clinical pharmacist agency to provide pharmacist support to the practice team. The service was underpinned by an agreement with clear expectations and standards. The lead GP monitored the performance of the service received.
- The practice was in the process of recruiting a nurse practitioner who was an independent prescriber at the time of this inspection. The lead GP had reviewed their prescribing practice as part of the recruitment process.

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: 11 | Y |
| Number of events that required action: 11 | Y |

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

| Event | Specific action taken |
|---|--|
| The practice had identified a major significant event when it was realised that administrative records (such as meeting minutes and policy documents) had been deleted from the shared drive and were not immediately accessible. | The missing materials were catalogued with some being retrieved from back up files and others needing to be rewritten. The practice had identified the need to have clear back up protocols in place and had discussed this with the relevant IT provider to minimise the risk of this type of incident reoccurring. |

| Safety alerts | Y/N/Partial |
|--|-------------|
| There was a system for recording and acting on safety alerts. | Y |
| Staff understood how to deal with alerts. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>Our standardised searches included searches to assess whether the practice was implementing the recommendations in selected recent safety alerts. We found that the practice was implementing safety alerts appropriately.</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 assessed, and care and treatment were generally delivered in line with current legislation, standards and evidence-based guidance and tools.

| | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Y |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Y |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Y |
| Patients' treatment was regularly reviewed and updated. | 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 search of the practice electronic records system to assess how the practice was managing aspects of care for patients with certain long-term conditions: asthma, chronic kidney disease (CKD), hypothyroidism and diabetic retinopathy. The results showed the practice was generally managing patients appropriately. However, we found some cases where patients' treatment should have been more actively reviewed. For example:</p> <ul style="list-style-type: none"> We carried out a search of how the practice was monitoring hypothyroidism (190 patients). The search indicated that up to 18 of these patients might not have received monitoring when due. We reviewed a sample of 5 of these patient records in more detail and found that 2 of these 5 patients were overdue monitoring with the other 3 being managed appropriately. This was a marked improvement since our previous inspection but remains an area for further focus. We identified one additional area for improvement from our searches. The practice was not routinely following up patients who had been prescribed oral steroids for an acute exacerbation of asthma within the | |

timescale recommended in current guidelines.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate follow-up 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.
- Patients with poor mental health, including dementia, were referred to appropriate services. The practice assessed and monitored the physical health of people with serious mental health problems.

Management of people with long term conditions

Findings

- 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.
- The practice had improved its management of patients with asthma since our previous inspection, with the number of patients prescribed multiple SABA inhalers being markedly reduced. Patients were routinely provided with asthma plans and this was recorded in their notes.
- The practice used Quality and Outcome Framework (QOF) registers to manage and monitor patients with long-term conditions. The lead GP ran QOF clinics for patients with more complex presentations of long-term conditions.
- The practice used electronic templates to ensure long-term condition reviews were structured and their clinical needs are addressed.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Our standardised searches of the practice electronic records system identified 2 patients who had not been identified or coded as having chronic kidney disease despite this being indicated by their recorded test results. The practice told us they would review the reasons for these diagnoses not being coded correctly on the system.

| 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) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 66 | 77 | 85.7% | Below 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 63 | 72 | 87.5% | Below 90% minimum |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 53 | 72 | 73.6% | Below 80% uptake |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 51 | 72 | 70.8% | Below 80% uptake |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 51 | 78 | 65.4% | Below 80% uptake |

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

Any additional evidence or comments

- The practice was not achieving the World Health Organisation targets for childhood immunisations in 2021/22 although it was achieving close to 90% for the one year-old cohort and for the PCV booster. The practice had improved on uptake of the pneumococcal booster immunisation since our previous inspection in 2022 (from 80%).
- The practice had evidence to show how it was encouraging uptake of childhood immunisations, such as telephoning families for health education and discussion at family appointments about the benefits of immunisation. The GPs personally spoke with families who had concerns around immunisation and had successfully encouraged some to attend for their immunisations.

| 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) | 59.5% | 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) | 58.7% | N/A | 70.3% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA) | 62.5% | 55.1% | 54.9% | No statistical variation |
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (6/30/2023 to 6/30/2023) (UKHSA) | 69.6% | N/A | 80.0% | Below 70% uptake |

| Any additional evidence or comments |
|---|
| The practice actively encouraged patients to attend cervical cancer screening appointments and scored relatively highly on this compared to other practices in the local area. Breast and bowel cancer screening rates had remained static since our previous inspection in 2022 and also remained an area of active focus within the practice. |

Monitoring care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Clinicians took part in national and local quality improvement initiatives. | Y |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | Y |
| <p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> The practice had carried out a two-cycle audit of its coding and management of depression. The first cycle highlighted cases where the condition had not been correctly coded or dated which impacted on follow-up reviews. The second cycle showed improvement with significantly fewer patients waiting for a review. The practice had introduced more systematic and routine auditing of selected medicines which require ongoing monitoring. The practice had improved its systems to implement national patient safety alerts since the previous inspection and ran searches to ensure that relevant alerts were implemented. | |

- The practice had changed its call and recall systems for patients with long-term conditions so reviews were automatically triggered at the patient's birthday. This ensured a more systematic and predictable workflow across the year.

Effective staffing

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

| | Y/N/Partial |
|---|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. | Y |
| The practice had a programme of learning and development. | Y |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. | Y |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Y |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Y |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |
| Explanation of any answers and additional evidence: The practice had experienced a period of staff turnover in the year before the inspection. The practice leaders had learned from this experience and were able to provide examples of an improved approach to supporting and managing staff when performance was variable. | |

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 |

Helping patients to live healthier lives

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

| | Y/N/Partial |
|---|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. | Y |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Y |
| Patients had access to appropriate health assessments and checks. | Y |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Y |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had found that patient health checks were an effective method for identifying patients with undiagnosed conditions, for example high blood pressure.• There was a clear referral pathway for patients with obesity.• The lead GP described the provision of education on living healthily with diabetes as an ongoing priority for the local population. The practice had trialled a group for patients with diabetes the previous year and patients were able to see a specialist diabetes nurse at the practice. | |

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 plan. | Y |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. | Y |
| Explanation of any answers and additional evidence The practice had improved its recording around DNACPR decisions since the previous inspection. As part of this inspection, we reviewed 2 DNACPR forms. These had all been completed clearly with mental capacity being assessed. Discussions with patients and their families about patient wishes had been documented. | |

Responsive

Rating: Good

Responding to and meeting people's needs

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

| | Y/N/Partial |
|--|-------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | Y |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Y |
| The facilities and premises were appropriate for the services being delivered. | Y |
| The practice made reasonable adjustments when patients found it hard to access services. | Y |
| There were arrangements in place for people who need translation services. | Y |
| The practice complied with the Accessible Information Standard. | Y |

Practice Opening Times

| Day | Time |
|-------------------------|--|
| Opening times: | |
| Monday to Friday | 8am – 6.30pm |
| Appointments available: | |
| Monday to Friday | Morning and afternoon (Specific availability varied across the clinical team) |

Further information about how the practice is responding to the needs of their population

- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a young child were offered a same day appointment when necessary.
- Pre-bookable appointments were also available to all patients at additional locations within the area in the evenings and at weekends through the primary care network.
- The practice held a register of patients living in vulnerable circumstances and alerts were added to their patient records.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice was able to refer and signpost patients to a wide range of local services for example, counselling services tailored to the needs of young adults.

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 |
| Explanation of any answers and additional evidence: Patients could access appointments by telephone or submitting an online request or attending the practice in person. We were told that the online system had not proved popular with patients, for example, due to language barriers. The practice team was multilingual and members of the team could speak Hindi, Arabic, Punjabi and Urdu. | |

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) | 45.2% | N/A | 49.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023) | 65.4% | 57.4% | 54.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023) | 61.7% | 57.1% | 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) | 82.2% | 69.7% | 72.0% | No statistical variation |

Any additional evidence or comments

The practice continuously reviewed demand and adjusted the appointment system at busy times. The practice had moved to offering more face-to-face appointments in 2022 to meet patient needs and preferences.

| Source | Feedback |
|---------------------------------------|---|
| Patient participation group interview | We were told that access had improved since the COVID-19 pandemic and patients had seen positive changes. Patients were able to obtain same day appointments by ringing the practice in the early morning and early afternoon. Patients were also able to book to see their preferred doctor which was valued when discussing longer term conditions. |

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. | 11 |
| Number of complaints we examined. | 3 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 3 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

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

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|--|--|
| Patient and family were unhappy at the way the practice team responded when they did not want to share the reason for requesting a GP appointment. The problem was not effectively de-escalated and the practice subsequently received a formal complaint. | The practice reviewed the complaint and reflected on the need to respect people's privacy while communicating the reason for the request for more information. The complaint had been used as a learning point and the protocol for appointment booking had been updated. The complaint had been resolved. |

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. | Partial |
| Explanation of any answers and additional evidence: The lead GP had developed their ideas on succession planning since our previous inspection and had considered various options for the longer-term future of the service, for example should it prove difficult to attract one or more additional partners. In the immediate term, the responsibility for running and leading the practice was falling predominantly on the lead GP with the support of a business manager. | |

Vision and strategy

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

| | Y/N/Partial |
|--|-------------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Y |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Y |
| Progress against delivery of the strategy was monitored. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The lead GP had a clear vision for the service and was engaging with stakeholders in relation to service provision and available resources for the benefit of patients.• The staff team understood the values although there was more scope to develop the strategy in collaboration with others. | |

Culture

The practice had a culture supported 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 |

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

| Source | Feedback |
|-----------------------|---|
| Interviews with staff | Staff told us the practice was a good place to work and staff team was now working effectively to provide a caring and compassionate service to patients. The lead GP was described as approachable and supportive. |

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: <ul style="list-style-type: none">The practice was introducing an electronic document management system to underpin effective governance at the time of the inspection. Although some of the documentation we requested during the inspection was available, it was not always easy to locate. The practice had recognised this as an issue and the new system had the potential to improve the organisation and efficiency of non-clinical record keeping. | |

- The lead GP was responsible for governance arrangements with third parties. We saw evidence to show that they actively monitored third party contracts and other arrangements.
- The practice was staffed with long-term locum GPs. The locum GPs were invited to and attended clinical meetings and were included in practice communications, for example, the circulation of meeting minutes.

Managing risks, issues and performance

There were improved processes for managing risks, issues and performance.

| | Y/N/Partial |
|---|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Y |
| There were processes to manage performance. | Y |
| There was a quality improvement programme in place. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We found that the practice had improved its management of clinical risk since our previous inspection, for example, it now carried out regular audits of certain medicines that require ongoing monitoring. There remained some areas for further focus as identified by our standardised searches of the clinical records system, for example, more consistently following-up patients prescribed oral steroids for an acute exacerbation of asthma. • There were processes to manage performance. The lead GP provided evidence of how they had acted on performance issues that had been destabilising the team and affecting the quality of the service. The positive impact of these actions was corroborated by staff. | |

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 |

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. | Partial |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice was working on building relationships with local stakeholders for the long-term sustainability of the practice and the benefit of patients, for example in relation to the local allocation of available primary care network resources in the form of associated roles. The practice had an active patient participation group prior to the COVID-19 pandemic and this had continued since with quarterly virtual meetings. The group had been involved in developing ideas such as running a meeting for carers about the support available to them through the practice and locally. | |

Continuous improvement and innovation

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

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Y |
| Learning was shared effectively and used to make improvements. | Y |
| Explanation of any answers and additional evidence: | |

Examples of continuous learning and improvement

- The practice had acted on the findings of our previous inspection for example, carrying out more systematic monitoring of prescribing for medicines requiring ongoing monitoring and improving its implementation of national patient safety alerts.
- The practice had introduced a more systematic staff appraisal system to identify any issues, concerns or development opportunities at an early stage.
- The practice was carrying out more clinical audit, for example it had carried out a two-cycle audit of its coding and management of depression.
- The practice had changed its call and recall systems for patients with long-term conditions so reviews were automatically triggered at the patient's birthday. This ensured a more systematic and predictable workflow across the year.

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.