

Inspection Evidence Table

The Surgery@Aylestone

(1-1837625889)

Inspection Date:

Date of data download: 28/09/2023

Overall rating: Good

We previously inspected the practice in October 2019 and rated the practice as Good overall. We subsequently carried out an inspection in February and March 2022 to in response to information of concern received about the quality and safety of the service highlighting a lack of effective leadership and clinical oversight. During this inspection the overall rating was Requires Improvement.

As a follow up to this, we carried out this inspection on the 28th September 2023 and have rated the practice as Good overall. After the clinical searches and on-site inspection, we found there was safe patient care and governance oversight had been reviewed and now monitored the quality and effectiveness of the service through embedded systems and processes.

Context

The practice is in a purpose-built health centre which consists of five consulting rooms located on the ground floor and three consulting rooms located on the first floor.

The practice is situated within the NHS Leicester City Clinical Commissioning Group (CCG) and delivers General Medical Services (GMS) to a patient population of about 4200. This is part of a contract held with NHS England.

Information published by Public Health England shows that deprivation within the practice population group is in the fourth lowest decile (four of 10). The lower the decile, the more deprived the practice population is relative to others. According to the latest available data, the ethnic make-up of the practice area is 86% White, 3% ,6% Asian, 3% Black, 3% Mixed, and 0.7% Other

Safe

Rating: Good

During the inspection in February and March 2022 the practice was rated as Requires Improvement in Safe. This was because the practice did not have reliable systems in place for the appropriate and safe use of medicines. Staff did not always have the information they needed to deliver safe care and treatment. Clinical oversight of patient information including clinical data was not consistent.

At this inspection we found new systems and processes were embedded and helped deliver safe care. Our searches showed safe use of medicines and regular monitoring of patients to optimise treatment. There was a robust system in place to audit data. Specific named staff oversaw different audits to support safe care and treatment. The practice is therefore now rated Good for providing safe services.

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: <ul style="list-style-type: none">• There were dedicated safeguarding leads and staff were aware who to talk to about concerns if they arose.• DBS checks were completed for new staff and renewed every three years.	

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: <ul style="list-style-type: none">• We reviewed three staff files during the inspection they showed staff were employed in accordance with regulations and the required checks were carried out.	

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: April 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: May 2023	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> During the inspection we reviewed the changes following risk assessments which ensured safety procedures and equipment were in line with the latest guidance. 	

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:	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: <ul style="list-style-type: none"> During the inspection we saw changes made as a result of audits, for example there were new chairs for clinical rooms, so they met the requirements for infection prevention and control. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y

Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was occasional use of GP locums to bridge gaps in staffing. During the inspection we saw locum doctors had undergone induction and were aware of who to approach for support if needed. 	

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: <ul style="list-style-type: none"> There was a system in place to chart the progress of referrals to ensure patients were seen or followed up in secondary care. A batch report was run each week and patients were followed up if appropriate. Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients. 	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.69	0.75	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	8.4%	8.1%	7.8%	No statistical variation

antibacterial drugs (BNF 5.1 sub-set). (01/07/2022 to 30/06/2023) (NHSBSA)				
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	4.74	4.76	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	78.5‰	94.4‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.64	0.68	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	6.7‰	6.1‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of effective 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 medicines that require monitoring (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> <ul style="list-style-type: none"> During the inspection we reviewed all medicines stored in the practice and found they were kept in a locked room and checked regularly to ensure they remained safe to use. Fridges which were used to store medicines were checked regularly to ensure the medicine was stored safely. We ran a clinical search to see how many patients were on a medicine used to manage blood pressure. We found there were 364 patients on this medicine and 5 were overdue monitoring to ensure it was safe for them to be on the medicine. The practice had recalled these patients in the week following the inspection. We ran a clinical search to see patients recent blood results which might indicate they had diabetes or kidney failure and found there were no patients with a result which would indicate a potential diagnosis had been missed. We ran a clinical search to identify patients prescribed a strong pain relief and looked at the last time they had a review. Out of 51 patients we found 3 patients were overdue monitoring, however these all had a scheduled review in the next three weeks. We saw 307 patients had received a medication review in the last 3 months. We reviewed 5 random patients who had received a recent review and found they were at completed and documented appropriately. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months: 6	Y
Number of events that required action: 2	Y
Explanation of any answers and additional evidence:	

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

Event	Specific action taken
A patient was referred to the wrong team in secondary care.	<p>Once this was realised the staff re referred the patient and staff carried out training to understand referral pathways.</p> <p>We saw this was discussed at the meetings and staff were aware of the resulting changes.</p>

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> <ul style="list-style-type: none"> There was a system in place to disseminate alerts as they came in and all staff had access to the updates, the lead GP or pharmacist would make changes and inform patients where appropriate. We saw examples of actions taken on recent alerts, for example: <ul style="list-style-type: none"> We carried out a search for patients on patients over the age of 65 and on a mood stabiliser which had not had a dosage reduction in line with latest guidance. We found no patients on the incorrect dose. We carried out a search for patients on a pain relief patch and had not had any oral medication prior to starting, we found no patients receiving care outside of latest guidance. We carried out a search for patients on a cholesterol lowering medication and also on other medication which could increase the risk of falls. We found no patients receiving care outside of latest guidance. 	

Effective

Rating: Good

During the inspection in February and March 2022 the practice was rated as Requires Improvement for effective services. This was because at the time the approach to the management of patients care and treatment was inconsistent with limited clinical oversight.

At this inspection we have rated the practice good for providing effective services because the practice had a programme of learning and development to provide staff with the skills, knowledge, and experience to carry out their roles and we saw evidence of effective overall monitoring of patients with long term conditions.

We found that although the practice had not met the minimum 90% target for 4 out of 5 childhood immunisation uptake indicators or the 80% target for cervical screening, they had considered the possible causes for not meeting these targets and had started to think about ways to improve uptake in these areas.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y

Effective care for the practice population

Findings

- Patients 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 patients who met the criteria.
- The practice had systems to offer eligible patients 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. The practice worked closely with a local home for patients with a learning disability to provide care in the home as well as in the practice when possible.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. GPs would home visit when appropriate and coordinate care with community teams. A register of those patients nearing the end of their life was reviewed to ensure the correct support was offered.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Patients with poor mental health were referred to appropriate services.
- Patients with a diagnosis of dementia were signposted to community support groups and carers and relatives helped to access social support if they felt it beneficial.

Management of people with long term conditions

Findings

- During our clinical searches, we looked at patients with long term conditions and patients who require regular monitoring, such as blood tests, to ensure their treatment was optimised in line with national guidance.
 - Out of 52 patients on a medicine to prevent blood clots from forming, 1 patient had not had their routine bloods taken in the last 12 months. We found a request had been made for them to book an appointment, but the patient had not responded. They were due to be followed up prior to repeat medicines being prescribed next month.
 - Out of three patients on a medicine to stabilise their mood we found all had had routine bloods taken in the last three months.
- The practice-maintained registers of patients with long term conditions. Our searches found these patients received appropriate monitoring and reviews annually by the nurses and health care assistants.
- 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

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

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus 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)	50	54	92.6%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	37	44	84.1%	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)	37	44	84.1%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	38	44	86.4%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	58	65	89.2%	Below 90% minimum

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

Any additional evidence or comments

The practice had spent the year engaging with parents and carers who had not attended for immunisations. The current system ensured all possible opportunity to carry out immunisations were utilised for example:

- A dedicated member of the reception team maintained a register of patients eligible for immunisations, they would phone the parents or carers three times to offer convenient appointments.
- If telephoning the patients was not successful, then a letter would be sent.
- Following this, a practice nurse would make a phone call to explain the importance of the immunisations.
- If this was not successful, then a GP would also engage with the family to make sure they understood the importance of immunisations.

- If patients had not received their immunisations at after the practice had followed its process, then the patients would be referred to the local community paediatric service for them to support the family. They were then able to receive home visiting for immunisation from the community team.
- If the patients presented in the practice for another illness, then the opportunity would be taken to engage with the family around the immunisations and offer an appointment when appropriate.
- There was a weekly two-hour vaccination clinic which was at a convenient time for children and the nurses would be flexible in offering appointments at other times.

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)	65.6%	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)	66.3%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (3/31/2023 to 3/31/2023) (UKHSA)	74.4%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	26.7%	54.3%	54.9%	No statistical variation

Any additional evidence or comments

- The service had searches set up to alert them of patients who have not responded to their screening invites. Clinicians could discuss this at other appointments with patients who had not responded.
- The practice offered early morning, lunch and evening appointments for cervical cancer screening to ensure there were convenient appointments available.
- The service was set up to send a text message which contained a link to self-book in for an appointment to reduce the need to phone the practice.
- The reception team would phone three times to book the patient in for screening, if this was not successful then the lead nurse would make a call to ensure the benefits of screening were explained. This was also backed up with a letter to the patient.
- At the time of the inspection the practice had screened 78.4% of the eligible population and were working to engage with the remaining 180 patients.

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
We saw two audits run by the practice. One for cervical screening which showed an improvement on the previous year, and one on patients who took a medicine to reduce inflammation. This showed there was an improvement in monitoring on the second audit and had been discussed with clinicians at a monthly meeting.	

Effective staffing

The practice was able to demonstrate 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
<ul style="list-style-type: none">• In the last round of appraisals, the practice manager had added 360-degree feedback (a questionnaire sent to all staff for each employee to get additional perspectives to the appraisal) to everybody's annual appraisal which staff told us during the inspection they had found useful.• GPs audited decision making done by staff such as pharmacists and nurses and were available to support whenever they were needed. Monthly reviews were undertaken to support in areas such as record keeping, decision making and referrals.• Staff received and kept up to date with mandatory training. The practice utilised both online learning and in person sessions and the manager kept a training matrix to ensure staff were up to date. We saw this during the inspection, and it showed good compliance of training the practice deemed mandatory across all staff.	

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
<ul style="list-style-type: none">• We saw evidence of monthly multi-disciplinary team meetings which involved practice leads and community teams.• We also saw that clinicians engaged with local community teams to support patient care when appropriate.	

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
<ul style="list-style-type: none">• There were leaflets in multiple languages available to patients to give them information on subjects such as stopping smoking. The practice would sign post patients to local groups to support a healthier lifestyle where appropriate.	

Consent to care and treatment

The practice always obtained / was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<ul style="list-style-type: none">During the inspection we reviewed three Recommended Summary Plans for Emergency Care and Treatment (ReSPECT), these were all completed in the last year and had appropriate consent and documentation around capacity and family involvement.	

Caring

Rating: Good

At the last inspection the Caring key question was rated good. The practice continues to be rated good for providing caring services following this inspection.

Kindness, respect and compassion
Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

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 stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	67.5%	79.4%	85.0%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)	69.1%	77.4%	83.8%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	82.5%	90.2%	93.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	55.7%	64.2%	71.3%	No statistical variation

	Y/N
The practice carries out its own patient survey/patient feedback exercises.	N
The practice had received an average of 4-star online reviews at the time of inspection from patients. Feedback ranged from friendly and thorough service from clinicians, welcoming and efficient staff and an effective telephone booking system, to unhelpful reception staff and difficulty booking appointments over the phone The practice responded to any negative reviews in a sensitive manner.	

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
There were notices offering support with smoking cessation and healthy living in the reception area. These were available in easy read format or other languages when requested.	

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 stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	80.5%	86.2%	90.3%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	146 (3.5%)
How the practice supported carers (including young carers).	The practice told us that they have a carers champion and that they update their notice board regularly with different signposting services.
How the practice supported recently bereaved patients.	The practice told us that they have a template letter they send out to patients' families with signposted services. Next of kin would be contacted if they were a registered patient and support offered.

Privacy and dignity

The practice respected / did not always respect patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Requires Improvement

At the last inspection the Responsive key question was rated good. Following this inspection, the practice is rated as requires improvement for providing responsive services following this inspection. This is because the national GP survey results are lower than local and national averages, and although the practice has implemented changes there is not yet evidence to show it has improved patient experience.

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	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 7.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 7.30pm
Friday	8am – 6.30pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- There was a medicines delivery service for housebound patients through local pharmacies which the practice would signpost to if a patient had become house bound.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 7.30pm on a Thursday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Appointments were available every fifth Saturday from 9am-5pm as part of the local GP federation and other practices were open for patients to be seen on the other four weekends.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. The practice had a local home for patients living with a learning disability and would visit the home for annual health checks if appropriate or see patients in clinic if they were comfortable to attend.

The practice had recently run an access audit by sending a web link to patients following an appointment to see if changes implemented were having an effect.

The practice carried out an annual satisfaction audit by handing out leaflets in the waiting area, this was reviewed at staff meetings to find areas for improvement.

Access to the service

Some 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.	P
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.	P
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • All appointments were triaged by phone to ensure the most suitable outcome was available. After this, patients were either offered treatments over the phone, seen face to face in the practice or a home visit appointment was allocated. <p>In response to the latest patient survey the practice had implemented some changes, these included:</p>	

- The practice had added three online bookable appointments a day to help patients' book an appointment without phoning the practice.
- The practice had a new website which had helped explain the appointment system in place.
- Patients were offered a second opinion with another clinician if they felt it would be beneficial.
- The practice had taken on a regular locum every Thursday to increase GP availability.
- The practice told us that they had a diverse workforce where staff spoke multiple languages and support was provided for patients who were considered digitally deprived.

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)	46.4%	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)	43.9%	47.9%	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)	40.3%	50.7%	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)	59.5%	66.7%	72.0%	No statistical variation
<ul style="list-style-type: none"> • The practice had undertaken a review of the latest National GP Patient Survey. We saw an action plan which showed changes the practice was in the process of making. This was shared with all staff and the Patient Participation Group (PPG) for feedback. • The practice had made changes because of the National Patient Survey results to improve access for patients. As yet, there was no evidence that changes have impacted positively on improved patient satisfaction. <p>The practice had undertaken an access audit in June 2023. The outcomes showed:</p> <ul style="list-style-type: none"> • Out of 17 patients surveyed four patients had waited more than 14 days for their appointment, however seven had been seen on the same day. • Out of 17 patients surveyed eight patients had waited more than 10 minutes on the phone with two waiting less than two minutes and three waiting between two and four minutes. 				

- Out of 17 patients surveyed 11 waited up to four minutes at reception and only three waited more than ten minutes.
- Out of 17 patients surveyed five were very unhappy with the appointment access and five were happy with the appointment access. Three patients said they were very happy with the appointment access.

In data made available following the inspection the practice had undertaken a patient satisfaction survey during September 2023. The outcomes showed:

- A majority of patients waited between five and 15 minutes prior to their appointment to be seen.
- An equal number of patients answered they got to see their preferred GP 'a lot of the time' and 'some of the time'.
- A majority of patients were either 'very satisfied' or 'fairly satisfied' with the appointment times available.
- More patients stated it was 'not very easy' or 'not at all easy to get through to the practice by phone, however once through a majority of patients found the reception team were 'very' helpful.

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.	5
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 of learning from complaints.

Complaint	Specific action taken
A discontinued medicine was prescribed to a patient. Once this was realised there was a delay in rectifying the issue and prescribing an appropriate alternative	<p>The practice pharmacist reviewed the prescribing with GPs and all staff are aware of the medicine being discontinued.</p> <p>In future a duty doctor will amend the medicine if a patient experiences the same issue to allow for a prompt substitute.</p>

Well-led

Rating: Good

During the previous inspection in February and March 2022 the practice was rated as Requires Improvement for well-led services. This was because there was a lack of clear and effective accountability and oversight to support good governance. Systems and processes were not always embedded to ensure risks were assessed and managed.

At this inspection we found there was inclusive and effective leadership throughout the practice and teams had come together to improve accountability and oversight. We found systems and processes were embedded in the day to day working of the practice and risks were assessed and managed. Staff we spoke to felt supported and positive about working together to improve patient care where possible. The practice is now rated as good for providing 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: <ul style="list-style-type: none">• The provider told us that they believed their biggest challenges to be meeting patient demand. They told us that they were continuing to work on improving access, had introduced new systems such as telephone appointments for appropriate patients and were continuing to improve uptake in the areas of cervical screening and childhood immunisations.• There was a business development plan in place which set out the objectives and priorities over the next five years	

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 introduced an admin huddle in the morning to assign staff to meet demand and ensure every employee were aware of latest information and availability.</p> <p>Following the previous inspection, the practice had worked with The Royal College of General Practitioners (RCGP), the local Integrated Care Board (ICB) and local pharmacists to create an action plan to improve access and highlight changes they could plan for in the future.</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.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
CQC staff questionnaires	<ul style="list-style-type: none"> • There were good relationships among staff across all levels. • There were enough staff employed at the time of inspection. • Significant events and complaints were discussed at meetings and learning was shared. - Practice leaders put a strong emphasis on staff safety and well-being. • Staff felt comfortable raising concerns or reporting something that has gone wrong. • The current appointment system was working well for staff and patients but there was still room for improvement.

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:	

- The provider told us that policies and procedures were in place that were regularly reviewed and available in both digital and hard copies, so they were accessible to all staff

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

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

Governance and oversight of remote services

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

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The local social prescriber attends local events and brings back topics which have arisen so they can be addressed in the practice or considered for future sign posting on notice boards.</p> <p>A GP and social prescriber attend a local diabetic support group to help with lifestyle changes and improve the open conversation around the condition.</p> <p>There was an active Patient Participation Group of seven members. They met in the practice every two months and discussed concerns and recent issues which had been flagged. They help to promote access changes such as the late opening and additional online access.</p>	

Continuous improvement and innovation

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

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

The practice told us that there were opportunities for career progression and clinical staff regularly attend external courses, for example the practice nurse forum lead would send monthly emails of available training which was always encouraged. Staff told us they had attended courses they requested during their appraisals.

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.