

# Care Quality Commission

## Inspection Evidence Table

### Dr PV Gudi and Partner (1-567984268)

Inspection date: 23 September 2022

Date of data download: 13 September 2022

## Overall rating: Requires Improvement

At our previous inspection in December 2021 we rated the practice as requires improvement overall as improvements had been made following previous inspections, however governance processes still needed strengthening to ensure risks to patients were mitigated. At this inspection we found further improvements had been made, however the practice continued to have areas of non-compliance with the Health & Social Care Act (Regulated Activities) Regulations 2014. We identified issues related to the management of safety alerts, actioning of tasks and ineffective processes for the management of poor performance. We have continued to rate the practice as requires improvement overall.

## Safe

## Rating: Requires Improvement

At the previous inspection in December 2021, we rated the practice as requires improvement for providing safe services as we found clinical consultations lacked detail and safety netting. At this inspection we found improvements had been made in the recording of information during a consultation with patients, however not all safety alerts were actioned appropriately, some patients had not received medicine reviews and we found outstanding letters and pathology results that had not been actioned. The practice continued to be rated as requires improvement 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

Safeguarding	Y/N/Partial
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"> <li>The practice demonstrated an effective and thorough process of ensuring safeguarding was a key part of patient care. Staff demonstrated clear awareness of their responsibilities around reporting incidents if they suspected a concern.</li> <li>The practice had policies and processes to support staff in this area and staff were clear on how they accessed these policies.</li> <li>Staff had completed safeguarding training relevant to their role,</li> <li>Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks were in place for staff as part of pre employment checks. This included enhanced and standard DBS checks based on the role and responsibilities of the job. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.</li> <li>Safeguarding was a standing item on the practice meeting's agenda and concerns were discussed with staff to ensure all staff were aware of the concerns. Alerts were also added to patient records to highlight safeguarding concerns.</li> <li>A monthly audit of the safeguarding registers was completed to maintain up to date registers and monitor the information that was held for each patient.</li> </ul>	

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"> <li>We looked at the recruitment files of two recently employed staff and found recruitment checks in place. This included an induction checklist, immunisation status and DBS checks.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 7 September 2022	Y
There was a fire procedure. Date of fire risk assessment: 17 June 2022	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Evidence provided by the practice showed equipment was regularly calibrated and electrical items were PAT (Portable appliance testing) tested.</li> </ul>	

- Fire safety policies were in place and evidence was provided of a completed fire risk assessment.
- The practice had carried out a range of health and safety risk assessments. An action plan was in place and evidence was provided that actions were being completed. For example: To carry out an assessment of working at height. This was completed as staff used the step stool to obtain items from high shelves.
- All staff had completed fire safety training. Systems were in place for the regular checks of fire alarms, extinguishers and fire evacuation procedures.

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 22 August 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• All staff completed the relevant infection control training for their role through the online training system in place.</li> <li>• The practice had an action plan in place to address concerns identified during the infection control audit. For example: some of the furniture was worn, which posed a potential risk of infection spreading. The practice was reviewing the items that needed replacing, however at the time of inspection had not changed the identified items.</li> <li>• Policies, procedures and audit templates were in place for infection prevention and control and accessible for all staff.</li> <li>• We observed the general environment to be clean and tidy.</li> </ul>	

## 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:	

- Staff had completed sepsis awareness training and had access to emergency medicines if required.
- The practice had increased the number of staff at the practice to provide extra appointments. This included locum GPs and two health care assistants.

## 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. <sup>1</sup>	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.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• During the remote review of the clinical system we found 125 outstanding letters awaiting action. A total of 38 letters were dated up to two weeks prior to the inspection.</li> <li>• We found 87 pathology reports awaiting action. On reviewing the reports, we found 50 were abnormal. At the time of the inspection 10 had been reviewed and 40 were still waiting action. More than 25% of the reports were older than seven days and had not been filed into the patients' clinical records. A further review showed 14 abnormal reports were older than three days and 12 had not been viewed by a clinician for further action. The leadership team were aware there was an issue with workflow and had distributed some of the outstanding work to other clinicians for action. However, the practice were unable to demonstrate they had a clear system in place to manage the potential risk to patients if tasks and documents were not actioned in a timely manner.</li> <li>• The practice had a system in place for the management of referrals under the two week wait process. Monitoring processes were in place to identify patients who were referred using the two week pathway and to ensure the pathway was used appropriately.</li> <li>• At the previous inspection we had found the standard of consultation records for one of the GPs lacked sufficient information and safety netting. At this inspection, we reviewed a random sample of five clinical consultations and found information had been clearly documented.</li> </ul>	

## Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.78	0.83	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	6.5%	6.1%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.66	5.20	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	102.3‰	138.8‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	1.24	0.66	0.59	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	6.1‰	8.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. <sup>1</sup>	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. <sup>2</sup>	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"> <li>• The review of clinical records showed 55 patients had been had received more than 10 prescriptions for sedative medicines. We reviewed a random sample of five records which showed each patient had particular complexities associated with their underlying health conditions and therefore it was appropriate they had continuous prescriptions authorised. However, we found four of these patients had not had a medication review coded in their records for over 12 months.</li> <li>• Patient Group Directions (PGDs) and Patient Specific Directions (PSDs) had been signed appropriately.</li> <li>• There was clinical oversight for all requests for medicine changes and a clear process was in place to demonstrate what actions had been taken.</li> <li>• We carried out random searches of patients prescribed high risk medicines and on reviewing a sample of patients' records we found prescribing was in line with guidelines and regular reviews were in place.</li> <li>• Emergency medicines and vaccines were appropriately stored and there were clear monitoring processes in place.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>Medicine fridges were monitored to ensure they were maintained at the correct temperatures for storing vaccines and other relevant medicines.</li> </ul>	

### 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:	six
Number of events that required action:	six
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice had developed a process of recording, acting and sharing information and learning outcomes as a team.</li> <li>We were told all staff were encouraged to report incidents. Staff told us all incidents were looked at and discussed at staff meetings to share learning.</li> </ul>	

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

Event	Specific action taken
Patient accident	Seen by nurse, to check for injury. Appointment made with GP immediately for further clinical review.
Fridge malfunction	Fridge temperatures showed fridge wasn't working properly. Reported to manufacturer to ask for advice. Data logger was checked for fridge temperature ranges NHS England vaccination team was contacted Vaccines destroyed following manufacturers guidance Completed incident form and reported on Datix.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence:	
The practice had a system in place for the recording of safety alerts, however we found the provider was unable to demonstrate that all relevant safety alerts had been responded to. On reviewing the	

clinical system, we found 147 patients on a medicine that is used to lower blood sugar in adults with type two diabetes. The alert was issued in 2019 and highlighted the rare side effect of Fournier gangrene associated with these medicines. We reviewed a random sample of five patient records and found three patients had been provided with information on the rare side effect, however the other two patients had not received any information.

## Effective

## Rating: Requires Improvement

At the previous inspection in December 2021, we rated the practice as requires improvement for providing effective services as we found systems and processes required further strengthening to ensure care and treatment was delivered in line with evidence based guidance and cervical screening targets remained below national targets. At this inspection we have continued to rate the practice as requires improvement as cervical screening targets remained below national targets and the leadership team were unable to demonstrate they had clear processes in place to address poor performance or monitor staff in clinical roles.

*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. <sup>1</sup>	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 prioritised care for their most clinically vulnerable patients.	Y



#### Explanation of any answers and additional evidence:

- On reviewing the clinical system, we found 706 patients on medicines used to lower blood pressure. We found 95% of patients were up to date with their monitoring. The outstanding 5% of patients who were overdue monitoring had been contacted on several occasions by the practice to attend for review.
- We saw care plans to drive forward patient care in areas such as learning disability reviews were in place.
- The practice used a range of clinical templates to support the management of patients' conditions, which linked in with the latest clinical guidance.

## Effective care for the practice population

### Findings

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

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care. On reviewing the asthma register we found 25 patients who had been prescribed two or more steroids in the past 12 months. We reviewed a random sample of five clinical records and found some patients had not received the standard dose of rescue steroids and had not been followed up appropriately.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

- 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 COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	75	76	98.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	43	97.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	41	43	95.3%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	43	97.7%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	55	65	84.6%	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 a dedicated nurse clinic for childhood immunisations on a Thursday morning, however patients were able to book appointments on other days if they could not attend the Thursday clinic. The practice followed up on patients that failed to attend.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	68.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	64.6%	55.7%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	59.3%	57.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	33.3%	50.3%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
The practice staff regularly review the list of patients that failed to attend cervical screening appointments and contact patients to encourage them to attend. The practice was in the process of obtaining leaflets in a range of languages to provide further information to improve uptake.

## Monitoring care and treatment

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

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

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

The practice shared with us an audit they had completed concerning a medicine used to treat nerve pain, anxiety, and some forms of epilepsy and the potential risk during pregnancy of physical birth abnormalities in the baby. The audit had identified eight patients who were on this medicine and within childbearing

age. The audit found no patients were at the risk of harm and information was provided to patients to reduce the risk of future harm.

## 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.	Partial
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:	
<ul style="list-style-type: none"> <li>• Quality standards along with other information such as complaints were discussed at staff meetings.</li> <li>• Most staff were very positive about working at the practice. Staff told us they received regular support from the management team, however some staff highlighted no improvements had been seen with the change in partnership.</li> <li>• Staff had clear roles and responsibilities and received regular appraisals.</li> <li>• The practice encouraged staff to report incidents and share learning. Staff told us they had no concerns in raising issues and felt well supported when reporting incidents.</li> <li>• The practice had no system in place to review the clinical consultations of staff employed in clinical practice, for example nursing staff. We were told templates were being implemented to commence these reviews.</li> <li>• The leadership team had identified variable performance of staff members which had the potential to impact on patient care, however they had no formal process in place to address this and take action. Following the inspection we received assurances that a process was in place to address the performance of staff members where variable and poor performance had been identified.</li> </ul>	

- A system was in place to monitor and review staff training and we saw high levels of completion rates for training specified as mandatory by the provider for staff. This included level three training for all clinical staff in safeguarding.
- Discussion with clinical and non-clinical staff demonstrated awareness and understanding in areas such as safeguarding and responding to an emergency.

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The clinical team had regular meetings with community teams and other organisations to ensure patients received co-ordinated care. These included palliative care and safeguarding. Evidence provided showed the last multi disciplinary team meeting had been held in July 2022.</li> </ul>	

## 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

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Y

## Caring

**Rating: Good**

At the previous inspection in December 2021, we rated the practice as requires improvement for providing caring services as patient feedback from the national patient survey was negative in a number of areas and the practice was unable to demonstrate they had an action plan in place to improve patient experience. At this inspection we have rated the practice as good for providing caring services as we found the practice had implemented a patient satisfaction questionnaire to gather patient feedback and had seen improvements in satisfaction scores of the National GP patient survey.

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was mixed 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

Patient feedback	
Source	Feedback
NHS UK	The practice had received seven mixed reviews. Comments related to lengthy waiting times and the helpfulness of staff.

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	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 (01/01/2022 to 30/04/2022)	82.1%	78.9%	84.7%	No statistical variation
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 (01/01/2022 to 30/04/2022)	80.4%	76.9%	83.5%	No statistical variation
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 (01/01/2022 to 30/04/2022)	92.9%	89.4%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	68.2%	62.2%	72.4%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Any additional evidence
<ul style="list-style-type: none"> <li>The practice had seen increased satisfaction scores in the National GP patient survey. For example: Results from the previous survey between January 2021 to March 2021 showed 82.6% of patients stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw. Results from January 2022 to April 2022 showed the practice had achieved 92.9% for the same question.</li> <li>Following the last inspection, the practice had implemented a patient survey to gather patient feedback. The survey was carried out in July 2022. The practice had received a total of 100 responses. An action plan was being planned to improve patient satisfaction. For example: The results of the survey showed 73.5% of patients said the GP put them at ease. The results of the survey were planned to be discussed with the staff to implement ideas for improvements.</li> </ul>



## 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

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	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 (01/01/2022 to 30/04/2022)	87.8%	85.1%	89.9%	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice had access to a social prescriber who provided support and advice to patients on a range of non-clinical services that were available locally.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	The practice had 137 carers on the carers register, this represented 2% of the practice population
How the practice supported carers (including young carers).	The practice offered flu vaccinations and health checks to carers and had a social prescriber available to provide advice on local support available.
How the practice supported recently bereaved patients.	An appointment was offered with one of the GP partners if required to offer support and advice. Information to support families during times of bereavement was also available by accessing the practice website.

## Privacy and dignity

### The practice respected 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: Good

At the previous inspection in December 2021 the practice was rated as good for providing responsive services. At this inspection we found no significant changes in the evidence we reviewed in relation to the responsive key question and the practice continued to be rated as 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Due to the impact of COVID-19 the practice had adjusted the delivery of appointments, with telephone triage being implemented for clinicians to assess whether a patient needed a face to face appointment.</li> <li>• The practice had information on evening and weekend appointment availability in a range of languages to support patients who did not have English as their first language.</li> </ul>	

#### Practice Opening Times

Day	Time
Opening times:	
Monday	8am to 8pm
Tuesday	8am to 8pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	9am to 12.30pm / 4pm to 6.30pm Extended hours: 6.30pm to 8pm
Tuesday	9am to 12.30pm / 4pm to 6.30pm Extended hours: 6.30pm to 8pm
Wednesday	9am to 12.30pm / 4pm to 6.30pm
Thursday	9am to 12.30pm / 4pm to 6.30pm
Friday	9am to 12.30pm / 4pm to 6.30pm

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

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. The practice had achieved gold standard in July 2022 following the completion of the Public Health England audit tool which showed 90.9% of annual health checks for people with a learning disability had been completed.
- 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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- 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 on a Monday and Tuesday 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.
- The practice was open until 8pm on a Monday and Tuesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a primary care network. Appointments were available Saturday from 9am to 5pm.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize 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:	
<ul style="list-style-type: none"> <li>• NHS 111 had direct access to the practice clinical appointment system and could book appointments for patients that required to see a GP urgently.</li> </ul>	

- As part of the primary care network, the practice had access to social prescribers and a community pharmacy to provide patients with a range of services to meet their needs.

### National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	55.3%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	54.0%	46.1%	56.2%	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 (01/01/2022 to 30/04/2022)	45.2%	48.6%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	54.4%	64.8%	71.9%	Tending towards variation (negative)

### Any additional evidence or comments

- The practice had increased the number of appointments available by using regular locums to provide this service.
- Results from the inhouse patient satisfaction survey showed 64% of patients found it easy to get through to someone on the telephone and 70.8% of patients said the practice was open at convenient times.

Source	Feedback
NHS Choices	Feedback on NHS choices was mixed concerning appointment availability and the length of waiting times when at the practice for an appointment.

### Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

<b>Complaints</b>	
Number of complaints received in the last year.	Six
Number of complaints we examined.	Three
Number of complaints we examined that were satisfactorily handled in a timely way.	Three
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero

	<b>Y/N/Partial</b>
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice had a system in place to record complaints. Evidence provided showed six complaints had been received in the past 12 months.</li> <li>• A complaints policy was in place and all complaints were discussed at staff meetings to share learning and implement improvement plans to improve patient satisfaction.</li> </ul>	

Example(s) of learning from complaints.

<b>Complaint</b>	<b>Specific action taken</b>
Delays in getting prescriptions	<ul style="list-style-type: none"> <li>• Practice wrote to patient to apologise</li> <li>• The prescription request was actioned</li> <li>• Patient was contacted to advise prescription was ready for collection</li> <li>• Discussed at staff meeting to ensure prescriptions were actioned in a timely manner</li> </ul>
Difficulty in getting appointment for blood tests and vaccinations	<ul style="list-style-type: none"> <li>• Practice spoke with patient</li> <li>• Organised appointment with GP to discuss concerns</li> <li>• Appointment with nurse was arranged for vaccinations</li> </ul>

## Well-led

## Rating: Requires Improvement

At the previous inspection in December 2021, we rated the practice as requires improvement for providing well-led services as we found communication amongst staff required strengthening and leaders could not fully demonstrate they had the skills to deliver high quality care. At this inspection we found some improvements had been made in communication, however clinical oversight continued to require strengthening to ensure high quality care was provided. We have continued to rate the practice as requires improvement for providing well-led services.

### Leadership capacity and capability

**Leaders could mostly demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	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.	Partial
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The leadership team had implemented changes following the retirement of one of the GP partners. This included a clinical pharmacist joining the partnership, an increase in administration staff and regular GP locums to provide more appointments. The provider had endeavoured to manage the change to the partnership without impacting on patient care. The provider had a strategy and supporting objectives to respond to challenges, however not all staff felt these were fully effective or implemented.</li> <li>We received mixed reviews from staff we spoke with about the leadership team being visible and approachable. The majority of staff said the practice management team were supportive, however some staff felt that communication with senior leaders was difficult and had seen no improvements since the change in partnership.</li> <li>Staff met regularly to discuss any issues. A range of meetings were in place to share updates with staff.</li> </ul>	

### 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:

- The practice had a mission statement on display which stated the practice aimed to provide the best possible care to patients with the available resources.
- As part of the strategy for improvement, the leadership team were working together to ensure new ways of working were implemented, monitored and reviewed on a regular basis to demonstrate sustainability and quality.

## Culture

**The practice culture did not always effectively support high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
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.	Partial
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The leadership team were aware that there had been a breakdown in communication with some staff at the practice, which had led to work not being completed in a timely manner. We were unable to gain assurances of a formal process in place to address variable performance.</li> <li>• We spoke with a range of staff during the inspection and found the majority of staff felt well supported. However, some staff said their workload was becoming increasingly difficult to manage and felt they needed more support which was not provided.</li> </ul>	

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

Source	Feedback
Various staff	Staff told us they felt part of the team and communication had improved since the last inspection in December 2021, with staff being kept up to date of any changes.

## Governance arrangements

**There were some 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.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice had systems in place to ensure all staff were clear on their roles and responsibilities. Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place.</li> <li>• Communication was effective and organised through structured, minuted meetings. Governance and performance management arrangements were proactively reviewed and reflected best practice.</li> <li>• The leadership team was aware of a backlog of tasks including letters and blood test results awaiting action. They told us they had brought in extra staff to address this, however during the inspection we found outstanding tasks awaiting action, some of which were abnormal and required urgent action. The provider could not demonstrate they had an effective system in place to manage letters and test results.</li> <li>• There was a good relationship with community teams to ensure patients received effective co-ordinated care.</li> </ul>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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"> <li>• The practice had a range of assurance systems in place, however these needed strengthening to ensure risks were mitigated. For example: the actioning of safety alerts.</li> <li>• The leadership team had identified concerns in the management of tasks which included pathology results and hospital letters, however we were unable to gain assurances that there was a formal process in place that enabled the provider to monitor and address performance..</li> </ul>	

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• There were policies in place to support staff with utilising digital services securely and effectively. This included the process and procedures for telephone, email and video consultations.</li><li>• Online consultations took place in consultation rooms with the doors closed to protect the patients' privacy.</li></ul>	

## Engagement with patients, the public, staff and external partners

**The practice involved staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
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Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Patients complaints and suggestions were discussed at staff meetings to share learning and improve patient satisfaction.</li> <li>• The practice had no active patient participation group. Forms were available in reception for any patient that was interested in joining. Leaflets were also on display in the waiting area to encourage patients to attend a meeting.</li> <li>• The practice was trying to organise three patient representatives to join the primary care network patient participation group.</li> </ul>	

### 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:	
<ul style="list-style-type: none"> <li>• An effective process was in place to ensure all staff were up to date with the practice's mandatory training. Staff told us they were given the opportunity to develop and learn.</li> <li>• Regular team meetings were in place to ensure learning from significant events and incidents was shared to promote learning amongst the team.</li> </ul>	

### Examples of continuous learning and improvement

The practice had achieved an outstanding award completed by a health facilitation leader as part of the primary care network review of enhanced services for annual health checks of patients with learning disabilities during the COVID-19 pandemic. The award was to demonstrate the commitment and hard work the team had provided to ensure patients received the appropriate care during the pandemic.

## Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.