

Inspection Evidence Table

Collington Surgery

(1-552729262)

Inspection Date:

Date of data download: 31/05/2023

Overall rating: Requires improvement

We have rated the practice Requires improvement overall because:

- Governance systems and processes were not always effective.
- The practice did not have an effective system to identify, monitor and manage risks.
- The system to respond to patient safety alerts from the Medicines Healthcare products and Regulatory Agency (MHRA) required further improvement to be effective.
- The practice did not have effective oversight of training completed by staff or a policy which specified the mandatory training required by staff.
- Systems and processes to keep patients safe when using the service were not operated consistently and did not always follow national guidance.

Safe

Rating: Requires improvement

We have rated the practice Requires improvement for providing safe services because:

- The systems and processes to manage infection, prevention and control (IPC) were not completely effective and the practice did not have sufficient oversight of the risk.
- The system to manage and respond to patient safety alerts from the Medicines Healthcare products Regulatory Agency (MHRA) did not provide an effective response for all patients affected by alerts.
- The systems and processes to manage the stock of emergency medical medicines had not operated effectively at all sites and there was no system to manage or monitor the stock of emergency medical equipment.
- The practice did not have effective systems and processes to keep people safe. In particular, the systems and processes to manage health and safety premises risks, were not operated consistently and were not completely effective.

Safety systems and processes

The practice did not have 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.	N
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice policy stated that staff would complete safeguarding training to the levels indicated in national guidance. However, the practice's training matrix which recorded completed training showed members of both the clinical and non-clinical teams did not have their training requirement set to the correct level in the training system. For example, the requirement for some of the nurses was set at level 1 for adults and children and national guidance recommends it should be level 3. A member of the management team was set at level 1 and national guidance recommends it should be level 2.</p> <p>We sampled 4 staff files and found the following:</p> <ul style="list-style-type: none"> • The training matrix indicated a receptionist had only completed safeguarding training for adults. However, their staff file confirmed they had completed safeguarding training for both adults and children and to the correct level as indicated in national guidance. • The training matrix indicated a nurse had not completed any safeguarding training. However, their staff file had a record of completed training for both adults and children to level recommended in guidance. • The training matrix indicated a GP had not completed adult safeguarding training. However, their staff file showed they had completed training for both adults and children to the level recommended in guidance. • We did not check training records for the other member of staff. <p>These findings meant we were not assured the practice had a complete and accurate record of safeguarding training completed by staff or that national guidance to determine training requirements was being followed.</p>	

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

We sampled the recruitment files of 4 members of staff (3 clinical and 1 non-clinical) and found the practice did not have a documented record that a nurses' registration with the Nursing and Midwifery Council had been checked. In mitigation the practice assured us that this had been checked at the point of recruitment but accepted it had not been documented. This was supported by evidence that both the GPs had records of their registration with the General Medical Council in their recruitment files. We also did not find evidence of references for the 2 GPs sampled. We were told these staff had joined the practice straight from training and assurance had been taken by the practice that they had been accepted onto the GP registrar programme prior to employment with the practice. We were not assured a consistent system was operated.

We discussed the practice's policy for obtaining evidence of staff's immunity to communicable diseases and found it did not follow national guidance for staff working in healthcare settings because clinical staff were only required to demonstrate immunity to Hepatitis B. The practice explained immunity to other communicable diseases would be requested from staff. However, all staff were encouraged to have an annual influenza vaccination and their COVID-19 vaccinations when required, but staff would not be penalised for choosing not to.

We sampled staff's recruitment files and found 1 member of clinical staff had no evidence of vaccinations in their staff file. However, in mitigation the practice was aware and had asked if they could obtain this. We also found 2 members of staff (1 clinical and 1 non-clinical) had partial evidence. We did not check the record for the other member of staff. We were not assured the current system was effective and found no risk assessment to consider control measures to mitigate the risk for the members of staff or patients. In mitigation, the practice told us they were aware not all records of vaccination were obtained, and the practice planned to improve the system by creating a matrix to record this information centrally, rather than in staff's recruitment files. After the site visit the practice shared a log sheet to check staff's immunity to communicable diseases and told us this would be at the front of staff's recruitment files, however we were unable to confirm this system or process had begun or was embedded but the immunity required followed national guidance.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	N
Date of last assessment: Collington Surgery 21 March 2023 Date of last assessment: Pebsham Surgery 30 May 2023 Date of last assessment: Ninfield Surgery 27 April 2023 Date of last assessment: Sea Road Surgery 30 May 2023	Y
There was a fire procedure.	P
Date of fire risk assessment: Collington Surgery 6 September 2022 Date of fire risk assessment: Ninfield Surgery 22 August 2022 Date of fire risk assessment: Pebsham Surgery 26 August 2022 Date of fire risk assessment: Sea Road Surgery 26 August 2022	Y
Actions from fire risk assessment were identified and completed.	P
Explanation of any answers and additional evidence: We found that health and safety risk assessments had been completed for all the sites. These had identified concerns or areas which required action to mitigate, reduce or remove the risk. For some of these items, either the action taken in response, or the intended action was documented with a target date. However, we also	

found examples where it was not clear whether further action was required or had been taken. For example, 1 of the risk assessments indicated that not all staff were aware of how to isolate the gas, water and electricity supplies in the case of an emergency and there was no information about any action taken or planned, to improve staff's awareness or remove this risk.

Fire risk assessments had been completed by external contractors competent to do so and these documents had action plans to improve the fire safety at the premises. Some actions had been completed, some were ongoing and for some actions it was not economically practical to undertake the work because of the cost involved. For example, there was a recommendation to improve the fire detection system at the Collington site, however, the practice was planning to move to new premises soon and had decided not to do this work because it was not economically viable. However, the decision had not been recorded on the action plan to close the action.

We also found recommendations to increase the number of fire wardens at the sites. We discussed this with the practice and were told because of working patterns, everybody at the practice was trained to be a fire warden. However, the practice training matrix only recorded 3 members of staff had completed this training. We requested evidence of fire warden training certificates for a sample of 4 staff who were recorded as fire wardens at the Collington site, and these showed they had completed fire safety training but not fire warden training. In mitigation the practice confirmed there were 4 training sessions planned for all staff in September 2023. However, the fire risk assessments had been completed between August and September 2022 for the 4 sites, which did not assure us that prompt action was taken to respond to risk when identified.

The practice had fire procedures and we found fire alarms and emergency lighting were tested on a scheduled basis. We found fire drills had been completed twice yearly at Collington, with the most recent fire drill on 7 June 2023 and the last drill at the Pebsham branch was 5 June 2023. However, the last recorded fire drill at Ninfield Surgery was 21 January 2022.

These findings did not give complete assurance that the practice had an effective response to the risk of fire and opportunities to improve this existed.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: Collington Surgery 11 May 2023 Date of last infection prevention and control audit: Ninfield Surgery 11 May 2023 Date of last infection prevention and control audit: Sea Road Surgery 2023 Date of last infection prevention and control audit: Pebsham Surgery 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

The practice had 2 members of staff responsible for infection prevention and control (IPC) and each were responsible for 2 sites. We requested evidence of specialist training for these staff and found the following

- 1 had last completed training 20 July 2016. However, in mitigation the practice explained this member of staff had planned to do update training at their last employer, but it had been cancelled during the pandemic and they were booked for training in September 2023. Although, we did not see evidence to confirm this.
- 1 had completed level IPC training in December 2020, but it was not clear that this was specialist training for IPC leads and had completed level 2 IPC training on 20 June 2023 because their previous training had expired in February 2021.
- The practice training matrix indicated many staff in clinical and non-clinical roles had not completed IPC training.

We were therefore not assured all staff had completed or were up to date with appropriate IPC training. After the inspection the practice provided additional information that the IPC leads attended meetings and received updates. However, because this information was received after the inspection, we were unable to confirm the effectiveness of this system to keep staff up to date.

IPC audits had been completed at all sites and the Collington and Ninfield sites had action plans which detailed the concerns identified by the audits, whereas the Pebsham and Sea Road audits did not have action plans, although areas for improvement were identified within the audits. For some of the concerns there was a recorded decision of the action to be taken or that the risk was accepted and a reason. For others there was no documented response to accept the risk or of the action to be taken to reduce it.

We sampled an item on the action plan and found the audit identified aprons were not wall mounted at Collington. The list of concerns did not document any decision or action to be taken. We entered 3 clinical rooms but only checked this issue in 2 rooms and found aprons were not wall mounted in either room. After the inspection, we were told the practice had ordered apron holders but we were not provided evidence to confirm the order.

We also discussed another item on the action plan which indicated the room used for minor operations at Collington Surgery did not comply with the IPC standards required, however, it did not explain why not. We asked the practice and were told it was because the audit identified the chairs in the minor operations room were not made from an appropriate material. After the audit, the practice had assured themselves the chairs complied with the standards required, however, the action plan had not been updated with the rationale and evidence that this action was completed, and the risk removed.

After the inspection the practice provided further information that minor operations were only performed at the Pebsham Surgery not at the Collington Surgery site. The practice had reviewed the Collington Surgery IPC audit and this concern did not relate to that site. However, we were not assured that the practice had an effective system or oversight to manage the risk of infection.

We found the practice did not have records of cleaning at the Collington premises since 10 January 2023. However, in mitigation the practice told us the record book had just been replaced by the cleaning company and they had asked for the records. The practice immediately contacted the cleaning company who provided evidence of attendance by the cleaners since 2 January 2023 to the date of inspection. We found the premises at all the sites we visited to be clean, tidy, and free from clutter.

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.	P
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.	P
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The matrix of completed training at the practice indicated many staff had not completed basic life support for adults or children. Of the 3 recruitment files we sampled for training records, 1 contained a certificate of this training but this was dated 24 September 2019 and 2 did not contain any record of completed training. We discussed this concern with the practice who confirmed all staff had received training in basic life support, cardiopulmonary resuscitation (CPR) and anaphylaxis from an external training company. The practice policy was that clinical staff received annual training and non-clinical staff received training on a 3-year basis. We saw evidence at the Collington site that training had been completed as a practice on 18 August 2022. The outcome of this finding was that we could not be assured that all staff had completed appropriate basic life support training across the whole practice.</p> <p>The practice training policy did not specify the mandatory training courses staff were required to complete. We found examples of staff that triaged patients who had not completed formal training in identifying high-risk symptoms such as sepsis or acutely unwell patients. However, in mitigation we found:</p> <ul style="list-style-type: none">• Guidance documents to identify sepsis were available in all the reception areas and clinical rooms we inspected. After the inspection the practice provided further information to confirm every room and office had a sepsis poster for emergency reference. However, we did not observe every room during the inspection so were unable to confirm this.• Staff we spoke with were confident about how to identify acutely unwell patients and the action they would take if they did.• In the non-clinical member of staff's training record that we sampled we found they had completed sepsis training even though it was not mandatory training required by the practice.	

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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: We found the practice used audit to ensure 2 week wait referrals (TWW) were made in a timely manner and were not missed.	

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) (01/01/2022 to 31/12/2022) (NHSBSA)	0.92	0.88	0.86	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). (01/01/2022 to 31/12/2022) (NHSBSA)	9.1%	8.4%	8.1%	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 (01/07/2022 to 31/12/2022) (NHSBSA)	5.62	5.84	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	197.6‰	156.8‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	1.09	0.84	0.56	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	14.3‰	10.2‰	6.8‰	Variation (negative)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	P
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	P
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>At our inspection in March 2019, we found there was a system to monitor patients taking medicines that require monitoring. However an audit of patients taking lithium identified that not all the practice's patients had had the required monitoring at the correct intervals. We sampled patients records and found patients overdue monitoring. We were therefore not assured that the practice had an effective system to monitor patients taking high risk medications. This evidence formed part of a breach of regulation.</p> <p>At this inspection our remote clinical searches identified 19 patients were prescribed lithium. All patients had had their lithium levels checked but 8 patients had not had all their other blood monitoring checks. Our GP specialist advisor reviewed a sample of 5 of the 8 patient records identified, to review the quality of the monitoring and care. The GP specialist advisor found none of the 5 patients had had their calcium levels checked within the required period, however, in mitigation, 1 of the patients had only started taking lithium in</p>	

March 2023, so was not overdue monitoring. We discussed this with the practice who were aware that guidance recommended calcium is included in monitoring tests and that it was not always consistently requested, and they told us they planned to review this at their clinical meeting and determine the practice process for this. We were assured the practice was aware of this opportunity to optimise the quality of care for patients taking lithium.

We found prescription stationary was stored securely and there was an effective system to monitor stock when in use at the practice. We inspected this process at 2 of the 3 sites and found it operated as intended.

Our GP specialist advisor completed remote searches of the practice's clinical system and reviewed a sample of 5 medication reviews. In 2 of the medication reviews they sampled, there was a documented record to explain what had been checked. However, in 3 of the patients records, it was recorded that a medication review had been completed but there was nothing documented to record what had been checked and we were unable to assess the quality of those 3 reviews.

We inspected the emergency medicines and equipment at all 3 sites we visited and found:

- There was an inventory of the required emergency medicines which was in line with national guidance.
- Expiry dates for these medicines were checked on a scheduled basis. We found this system had operated as intended at 2 sites, however, at 1 site we found an emergency medicine, Glyceryl Trinitrate, which is used to treat chest pain, was out of date. This was replaced by the practice immediately but the practice system to monitor expiry dates had not identified this.
- All sites had defibrillators and medical oxygen which were in date, but we did not find evidence that the practice kept an inventory of emergency medical equipment required at any of the sites we visited. We found the expiry dates of the defibrillator and medical oxygen were checked on a weekly basis at the Collington site but did not see evidence of a system to monitor expiry dates of other equipment. For example, at the Collington site we found the expiry date on an adults' oxygen mask had expired and there was only 1 set of adult and paediatric pads with the defibrillator. The practice immediately added a spare set of adult pads from another defibrillator and ordered paediatric pads. They also replaced the out-of-date oxygen mask. After the inspection, the practice confirmed emergency equipment was checked on a weekly basis but we did not see this evidence during the inspection so were unable to confirm this system was operating.
- At the Collington site, items were not stored together in one location. We were told that each room contained the equipment the practice felt was appropriate, but this posed the risk that in a medical emergency, staff could have to go to different rooms to obtain equipment, rather than having it in all, in one centralised location.
- All equipment at the 2 other sites was in date and was kept in a central location.
- All staff we spoke were able to tell us of the action they would take in a medical emergency. However, we found not all staff were not confident of the location of the emergency medicines and equipment at their site.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services: The dispensary was located at the branch surgery in Ninfield. We visited that site to interview a member of the dispensary team and carry out observations of the systems, processes and policies operated in the dispensary and found no areas of concern.</p>	

Track record on safety and lessons learned and improvements made.

The practice learned and made improvements when things went wrong, however opportunities to share learning more widely and improve the system existed.

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.	P
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.	P
There was evidence of learning and dissemination of information.	P
Number of events recorded in last 12 months: 4	Y
Number of events that required action: 4	Y
<p>Explanation of any answers and additional evidence:</p> <p>We found not all staff were confident of how to report a significant event, however, all were clear they would seek advice or guidance from a manager and that if they told a manager, the incident would be recorded for them, or they would be supported to do it.</p> <p>The practice had a system to record significant events which was available to all staff. We saw evidence that significant events were a standing agenda item in clinical meetings and opportunities to learn from the incident and make changes to systems and processes were discussed and taken. However, the evidence we reviewed showed that only clinical incidents had been recorded and we found 1 example where an incident affecting a patient could have been recorded as a significant event but was not. We also heard that outcomes of significant events tended to be shared with staff when the incident was relevant to them and not the whole staff group. This posed the risk that learning or changes made as a result of significant events was not shared throughout the practice. After the inspection the practice confirmed that if a learning point from a clinical significant event was relevant to the admin team, it would be shared and vice versa.</p>	

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

Event	Specific action taken
A patient was prescribed a medication they did not request.	The patient alerted the practice they had not requested the medication. The patient did not take the medication, so no harm was caused. The practice investigated the clinical system but did not find the cause of the error. The patient returned the medication and accepted the practice's apology. After review, the practice decided that a consultation record must be added to a patients' clinical record when any changes are made to medication without documentation to explain the reason for the change.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P
Staff understood how to deal with alerts.	P
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in March 2019, we found the practice received safety alerts from the Medicines Healthcare and products Regulatory Agency (MHRA) and were told staff ran searches to identify any patients affected by the safety alert. However, there was no record to document any action taken or evidence that learning or changes had been shared with relevant staff.</p> <p>At this inspection we were shown evidence of a log to confirm receipt of safety alerts and medicine recall notices and the action taken in response. We also reviewed the practice policy for managing alerts from the MHRA which clearly identified the responsibilities of staff and the process to be followed. However, our remote clinical searches identified 27 patients were prescribed Citalopram or Escitalopram at a dose higher than is recommended for their age which is contrary to a medicine safety alert issued in 2014. Citalopram and Escitalopram are used to treat depression and can increase the QT interval which can lead to a potentially fatal ventricular arrhythmia and this risk increases with age. (The QT interval is the time it takes for the ventricles of the heart to contract and relax). Our GP specialist advisor reviewed a sample of 5 patients and did not find anything in their records to indicate this risk had been identified, had been discussed with the patient or that alternative treatments had been considered. We requested the practice review 3 of these patients promptly due to the risk associated from other conditions and were assured by the action taken and response to 2 of the patients and the practice was actively trying to contact the remaining patient during the inspection period. The practice confirmed they would review the remaining patients identified by the searches but not reviewed by our GP specialist advisor.</p> <p>Our remote clinical searches indicated additional historic MHRA alerts may not have been responded to effectively because patients were identified in the search results. However, due to the methodology used at this inspection we did not review those records to confirm this. Because of the concern, we discussed the process with the practice and found the new system had been introduced after our last inspection in 2019 and had been updated after the merger of the 2 practices. Because of this, the practice responded that they needed to review their system and ensure all historic MHRA alerts prior to the merger were included in their log. They also identified they needed to develop a set of searches for patients which were repeated on an ongoing basis because, currently they were completed on receipt of an alert, but they were not repeated on an ongoing schedule. These findings demonstrated improvement had been made to the system and process, but further changes were required to ensure the practice responded effectively to all MHRA alerts, including historic alerts. After the inspection the practice confirmed that searches were run on a repeat basis but did not provide evidence to demonstrate this system and we were unable to confirm it was an embedded process because we did not observe it during the inspection process.</p>	

Effective

Rating: Requires improvement

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.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The remote clinical searches identified 21 patients were prescribed a disease-modifying antirheumatic medication (DMARD). These are used to treat autoimmune conditions and require regular monitoring to ensure that complications are identified early. In total we found 4 patients who were overdue monitoring tests to ensure it was safe for them to continue taking the medication. Under our methodology, our GP specialist advisor reviewed the records of 5 patients, 4 identified by the search and 1 patient chosen at random. The GP specialist advisor found no concerns for 3 of these patients because the prescriber had checked the patients records prior to prescribing, identified monitoring was overdue and acted appropriately in response. We discussed the remaining 2 patients with the practice and found the following:</p> <ul style="list-style-type: none"> • For 1 patient we saw the practice had recalled the patient for monitoring tests themselves in May 2023 and the practice told us they had advice from secondary care in January 2023 that the patients' blood results meant it was safe to continue prescribing the medication. • For the other patient the practice agreed the monitoring tests had not included all the required checks and the patient had been contacted for complete monitoring tests as indicated national guidance. The practice told us the patient would not be issued any further prescriptions until the results were received and confirmed it was safe to prescribe. • The practice also told us they would review their clinical governance processes including searches to audit the clinical system for patients on DMARDS. This was because the 2 patients of concern identified were under the age of 18, so the practice wanted to confirm this age group was included in their searches. 	

Our remote clinical searches also identified 442 patients with a potential missed diagnosis of chronic kidney disease (CKD) stages 3, 4 or 5. CKD is a reduction in kidney function or structural damage (or both) present for more than 3 months, with associated health implications. Our search identifies patients whose monitoring test results indicate they have CKD stages 3, 4, or 5 but have not been diagnosed with the condition. Our GP specialist advisor reviewed the clinical records of 5 patients and found all the patients were having appropriate blood monitoring, but 1 patient required further assessment by the practice. We shared details of this patient with the practice who confirmed they would review their care. However, these findings indicated the practice had not coded patients when diagnostic tests results confirmed the diagnosis of CKD. We followed this up with the practice who explained they had identified this concern themselves and had already completed a review of best practice guidance to improve the diagnosis and monitoring of these patients and shared evidence of the guidance document they had created with us. The practice confirmed this was scheduled for discussion at the next clinical guidance meeting. The practice also explained that since the COVID-19 pandemic they have struggled to ensure all patients respond to recall requests for monitoring tests. After discussion we were assured they were committed to reviewing this process to improve the accuracy of their clinical system.

Our GP specialist advisor also reviewed 5 records of patients over the age of 70 taking a non-steroidal anti-inflammatory drug (NSAIDs) or anticoagulant and who had not been prescribed a proton pump inhibitor (PPI) to protect the lining of the stomach and prevent adverse symptoms when taking the NSAID. Our search identified 347 of 848 patients had been prescribed a NSAID without a PPI and of the 5 patients reviewed we found:

- 1 patient was not taking the medication regularly and it needed to be removed from their list of medications in the clinical system.
- 3 patients required prompt review and we alerted the practice who told us, 1 patient had now been prescribed a PPI, 1 patient was at a lower risk from complications but would be followed up and they had not been able to reach the other patient to discuss their care.
- 1 patient was not at significant risk but required review by the practice.

The practice confirmed they would continue to attempt to recall the patients needing prompt review and the other patient identified to complete medication reviews and would review their clinical governance systems and processes for patients taking medicines requiring monitoring. However, we were not assured that the system, as operated was providing effective or safe care and treatment.

Effective care for the practice population

Findings

We also found:

- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- 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.
- The practice offered travel vaccinations included Hepatitis A and B, Typhoid and diphtheria, tetanus and poliomyelitis.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- All patients with a learning disability were offered an annual health check. Our GP specialist advisor reviewed a sample of the care plans and found comprehensive reviews had been completed which considered both the physical and mental wellbeing of these patients.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. The practice explained they worked in a multi-disciplinary team to deliver care for patients who were at the end of their life. The team considered the patients' needs and wishes to decide the most appropriate way to care for the patient. The practice also completed a review when a patient died to understand whether the patients' wishes had been met or if the practice could learn and make improvements.
- The practice assessed and monitored the physical health of people with mental illnesses
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

Our remote clinical searches found 96 patients with CKD stages 4 and 5 that had not received their routine monitoring urea and electrolyte (U&E) monitoring in the last 9 months. This test is used to check whether the electrolyte levels in the body are too high or too low as this can cause abnormal heart rhythms. Our GP specialist advisor reviewed the records of 5 patients and found all the patients reviewed had stable renal function and were being managed appropriately.

Our remote clinical searches also include review of patients with certain long-term conditions. We found the practice had 1160 patient on their asthma register and of these, 95 patients had been prescribed 2 or more courses of rescue steroids in the last 12 months. Our GP specialist advisor reviewed the records of 5 patients and all patients had their asthma assessed and managed appropriately. However, for 3 patients we did not find evidence asthma reviews had been completed in the last 12 months. The records showed the last review was in 2016 for 1 patient and 2020 for another patient. For the final patient we saw evidence the third patient had been recalled at the correct interval and had been followed up again but had not responded.

We found 1110 patients with a diagnosis of hypothyroidism and of those, the search indicated 90 had not received routine monitoring within the required timescales (hypothyroidism is a condition which means the thyroid gland is underactive and does not produce enough hormones). These monitoring tests check whether the amount of hormones produced by the thyroid are within the normal range and determine how it should be treated. Our GP specialist advisor reviewed 5 patients' clinical records and found no concerns with the

management of 2 patients and for another, although they were overdue monitoring tests, their last results were normal, and we found evidence the practice was aware and was actively recalling the patient. We highlighted 2 patients to the practice who provided confirmation they were aware these patients were overdue and had requested both to book blood tests. 1 had responded and the practice was actively recalling the other patient. We were assured by the management plan should this patient not respond to recall. However, the remaining patients required review.

Our remote clinical searches found 87 patients with diabetic retinopathy who had a HbA1c result greater than 74mmol/l at their last monitoring appointment (HbA1c is the average blood glucose (sugar) levels for the last 2-3 months and is used to give an indication of how well controlled a patient's diabetes is. Diabetic retinopathy is damage to the retina which, if not treated, can lead to loss of sight). We reviewed 5 of these patient's clinical records and found no concerns. All the patients had received comprehensive annual reviews of their diabetes and medicines reviews, including their diabetic medicines, in the last 12 months.

After the inspection the practice confirmed they would recall and review all the patients identified by the searches that required reviews or ongoing monitoring. However, we were not provided details of the process, such as an action plan, to complete this.

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)	101	110	91.8%	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)	136	154	88.3%	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)	136	154	88.3%	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)	136	154	88.3%	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)	137	159	86.2%	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

Because the practice had not achieved the minimum 90% target for 4 of the 5 indicators above, we discussed how the practice encouraged and supported parents to accept the offer of vaccinations for their children. We found:

- The practice explained they had a recall team which ran searches for eligible patients and sent reminders to the parents of those children. If there was no response, the practice used a different communication method, for example, a telephone call instead of a text message.
- To make the process as convenient as possible, the practice also offered combined appointments which included antenatal checks for mothers and the first round of vaccinations for babies.
- Where possible, nurses booked the next appointment while with the parents so they could address any concerns immediately and encourage uptake.
- To provide flexibility for parents of school aged children, the practice did not offer vaccination clinics, instead they offered appointments after school to prevent children from missing school.

The practice provided their unpublished, unverified data for childhood immunisation uptake as of 31 March 2023. This did not provide a direct comparison because the practice's data was from the Quality and Outcomes Framework (QoF), but the practice's figures showed:

- The total number children aged 1 that had had all their 8-week immunisations was 91%
- The total number children aged 1 that had had all their 8- and 12-week immunisations was 87%
- The total number children aged 1 that had had all their 8,12-, and 16-week immunisations was 85%
- The total number children aged 1 that had had all their 8,12-, and 16-week immunisations excluding rotavirus was 90%
- The number of children aged 2 that had had all their one-year immunisations was 84%
- The number of children that had all their preschool immunisations was 51%

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)	62.2%	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)	72.4%	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). (31/12/2022 to 31/12/2022) (UKHSA)	70.8%	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) (01/04/2021 to 31/03/2022) (UKHSA)	68.0%	63.5%	54.9%	No statistical variation

Any additional evidence or comments

Our data showed uptake of cervical screening was 70.8% which is below the target of 80%. We discussed cervical screening uptake with the practice who explained they were aware that uptake was lower than the target. The practice explained they had used patient feedback to improve their performance by identifying demand for blood tests and cervical screening appointments at the weekends, to make it more convenient for patients who were unavailable during the week, often due to work. The practice had responded by offering appointments on Saturday mornings.

The practice provided their unpublished, unverified data for cervical screening uptake as of 31 May 2023. This did not provide a direct comparison because the practice's data was from the Quality and Outcomes Framework (QoF), but the practice's figures showed 74% of women aged between 25 and 49 years and 79% of women aged between 50 and 64 years had an adequate cervical screening appointment.

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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice provided evidence of an audit aimed to improve the prevention of cardiovascular disease in a defined group of very high-risk patients who had diabetes. The details of the audit were:</p> <ul style="list-style-type: none"> • The objectives of the audit were to identify the number of patients with diabetes and existing cardiovascular disease who were potentially on suboptimal treatment and to review the identified cohort of patients and optimise their therapy where clinically appropriate. • The standards set for the review were taken from evidence-based guidance and research. • To identify patients eligible for the audit, the practice ran searches of its clinical system to identify patients with established cardiovascular disease and diabetes who either have not received a statin prescription in last 6 months or were prescribed a statin of sub-optimal intensity. • The practice provided evidence of the results and action taken to prevent cardiovascular disease for both groups of patients these demonstrated improvements to optimise the care of the identified patients. • The key recommendations of the audit were that education to raise awareness of the current guidance on cardiovascular disease prevention in at risk patients was important to improving care. Ongoing identification and improvement in lipids management is the key to improving cardiovascular risk in a large cohort of patients. • The practice shared the findings at their own clinical meeting, via email in the practice and, with the Integrated Care Board to help optimise the care of patients in the wider ICB area. 	

Effective staffing

The practice was unable 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.	P
The practice had a programme of learning and development.	N
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.	P
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice explained that where clinical staff were required to maintain registration with a regulatory body such as the General Medical Council (GMC) or Nursing and Midwifery Council (NMC), the practice routinely checked the registration was valid and kept a record in that member of staffs' recruitment file. We sampled the recruitment files of 3 clinical staff and found evidence of a check of the GMC website in 2 files. For another clinician we did not find evidence that the NMC website had been checked to confirm registration was valid. The system had not operated as explained by the practice.</p> <p>We found the practice had a training policy which confirmed staff were entitled to protected time for training. Staff we spoke with confirmed that although it could be difficult to find the time because the practice was busy, there were opportunities to complete training either:</p> <ul style="list-style-type: none"> • At specific practice training events or closures. • Requesting time for training with agreement from their line manager • Blocking time for training • Overtime could be requested by staff that preferred to train away from the practice environment. <p>However, we found, the practice training policy did not specify the mandatory training which the practice required staff to complete or the frequency which it needed to be updated. The practice explained that this had not yet been decided since the practice merged with another in July 2021. However, in mitigation, the practice shared minutes of a meeting in March 2023 where this issue was identified, and the following decisions were made:</p> <ul style="list-style-type: none"> • A training calendar with dedicated time for training should be created. • The training records of staff from both practices should be merged to create one completed training record for the practice. • The Primary Care Network had been creating a list of training required for each role. The practice would ask for the list to confirm training requirements. • A spreadsheet with the required training for each member of staff and due date/expiry date should be created. 	

However, during the inspection we did not find there was an effective system to demonstrate the practice had complete oversight of the training completed by staff or that staff had the necessary skills, knowledge or training to carry out their roles because we found:

- Because the training policy did not specify the training required by the practice, we were unable to analyse whether staff were not compliant with practice policy. However, the matrix of completed training indicated there were courses that were mandatory but had not been completed by staff.
- It was not clear how courses were assigned because it was recorded for some roles but not others. For example training in GDPR or GDPR awareness was not set as mandatory for a GP.
- We asked the practice about the process to record training and they explained that training was completed in the training system but if a member of staff did an external course, they were not able to upload this into the system. This meant they could not create a full record of training completed by that member of staff.
- The practice also told us they kept hard copies of training records in staff files which were printed from the training system used by the practice and included records of external training. However, of the 4 recruitment files we sampled, we found the training system indicated 3 members of staff had not completed safeguarding training, but when we inspected the hard copy training file, we found evidence of the training. We did not check training for the other member of staff.

These findings indicated the practice did not have an effective system which provided accurate oversight of completed training to the leadership and management.

We saw evidence of the practice policy for appraisals which stated they would be completed every 12 months. However, the practice shared the log to record when appraisals had been completed which indicated the following:

- Some staff were overdue appraisals.
- Some staff had their next appraisal date set beyond 12 months.
- Some staff had not received an appraisal according to the record.

We discussed this with the practice who explained that the appraisal was the formal point at which a member of staff's performance, learning needs and aims or objectives were discussed, but management operated an open-door policy and encouraged staff to raise matters outside of the appraisal process. The management was confident this was operating effectively and staff we heard from confirmed there was a very supportive environment, the open-door policy was in operation, and they were comfortable to raise concerns or needs to management.

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: The practice told us how it was important for them to ensure patients at the end of their lives received coordinated care and were able to express their wishes about how they wanted to die. The practice explained how they supported these patients by working with multi-disciplinary teams to ensure that medicines were prepared in a timely manner, referrals were completed, and every organisation involved in the patients' care had the information they needed to support the patient. For example, out of hours GPs or the ambulance service.	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with told us confidently about how they would determine whether a patient had the capacity to make decisions and consent to treatment.</p> <p>During the inspection we reviewed a sample of 5 patient's Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions and found these had been completed in line with legislation and identified the patients views about their care and treatment.</p>	

Caring

Rating: Good

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

Patient feedback	
Source	Feedback
NHS.UK website	We reviewed the NHS UK website and found there were 5 reviews in the last 12 months. All of them rated the practice 5 stars. The themes from the feedback included that the new phone system worked well, staff were friendly, the repeat prescription process was efficient, staff were caring and informative and, GPs explained things clearly to patients.
Patient Participation Group (PPG)	We spoke to a member of the PPG who spoke positively about their own experience of care. They told us they found all the staff to be friendly and professional and in the 5 years they had been a patient at the practice they had always been able to get an appointment in a timely manner. They also told us clinical staff explained what and why they were doing something clearly so they could understand and make decisions.

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 (01/01/2022 to 30/04/2022)	88.3%	86.4%	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)	90.2%	85.4%	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	98.7%	95.2%	93.1%	Tending towards variation (positive)

healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)				
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)	86.0%	73.6%	72.4%	No statistical variation

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

Any additional evidence

During the inspection we found evidence that the practice sought feedback from patients via a compliments and suggestions box in the waiting room at the Collington site. We also found evidence that patients were encouraged to send feedback directly to the practice manager. After the inspection the practice provided evidence that 1 clinician had been awarded a certificate of excellence from a rating review website for 2 consecutive years. This certificate was in recognition of consistently outstanding patient feedback. We were not provided any of the feedback that contributed to this award. However, we asked the practice if they had completed a patient survey and found they had not completed a formal survey themselves to identify areas for improvement. The practice told us they planned to restart the survey in the summer and explained that prior to the merger of the 2 practices in July 2021, both practices had completed patient surveys differently. For example, 1 practice had carried out their own survey, while the other had outsourced this to an external company. The practice now needed to decide how they would complete a patient survey as a merged practice.

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
<p>Explanation of any answers and additional evidence: The practice belonged to a primary care network (PCN) which offered several services to patients in the community. These included:</p> <ul style="list-style-type: none"> • A frailty and vulnerability coordinator • Support to anyone experiencing domestic abuse • A children's and young person's care coordinator • A Menopause service • A mental health support worker • Social prescribing services were available to patients. These included a drop-in clinic which patients could attend without an appointment. A social prescriber provides non-medical advice and directs patients to facilities and services in the community which can improve health and wellbeing 	

Source	Feedback
Give Feedback on Care submissions to CQC.	Due to the methodology used in this inspection, we did not speak to patients directly. We asked the practice to post a link to the 'give feedback on care' questionnaire on the CQC website during the inspection period and we received 34 responses from patients. 25 provided positive feedback, 4 provided mixed feedback and 5 submissions provided negative feedback. Themes from the positive feedback were that patients were happy with the care they received, found the practice to be very responsive to their needs and compassionate. Themes from the mixed and negative feedback included that some patients had not found the new appointment system to be an improvement and patients found it hard to contact the practice by telephone.

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 (01/01/2022 to 30/04/2022)	90.1%	92.1%	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
<p>Explanation of any answers and additional evidence: The practice confirmed patients had access to interpreters via a company which provided this service on behalf of the Integrated Care Board. Staff we spoke with during the inspection had details of the company and knew how to book an interpreter for patients.</p> <p>We found there was information about organisations and support groups for patients in the waiting areas of the sites. For example at the Collington site we found leaflets with information about:</p> <ul style="list-style-type: none"> • Support for patients with dementia, and for their families. • Organisations providing live in care for patients that wanted to remain living at home. • Advice and support after a stroke. • Bereavement support charities. • Support for patients and family members of patients with cancer. • Youth support • Mental health and financial support and advice. <p>Information leaflets to explain how the UK healthcare system works for patients that do not speak English as a first language were available in a range of languages which could be chosen by the reader.</p>	

The practice had limited information about support groups on their own practice website, however, there were details for their Primary Care Network website which provided more information about support available to patients in the community such as social prescribing, mental health support, cancer care, dementia care, children and young person's care coordinators, podiatry services and others. After the inspection the practice made us aware that they actively signpost patients to the Bexhill PCN website which contained details of support groups available in the local area.

Carers	Narrative
Percentage and number of carers identified.	4% (733 patients)
How the practice supported carers (including young carers).	Carers were supported through signposting to support services. For example, we heard of an example where a member of the team was concerned a carer was struggling emotionally with their partners diagnosis. The member of staff offered to refer the carer to a social prescriber. This was declined but the member of staff confirmed to the carer the offer would always be available.
How the practice supported recently bereaved patients.	The practice told us they sent a letter to the patients' next of kin to offer their condolences and support.

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

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Collington Surgery merged with Pebsham Surgery in July 2021. We were told the merger happened during the planning phase when both practices were looking for new premises in Bexhill. After both practices had investigated locations and buildings, both practices decided to take space in a new, purpose-built building shared with other healthcare services. As discussions about the planning and design of the building continued it was identified that Pebsham surgery had staffing shortages and practice's future was uncertain. The practices decided a merger would ensure their patients could continue to receive high quality and sustainable care for the future. The merged practice, Collington Surgery, has not finalised the arrangements for the new building yet but the planning for this is ongoing.</p> <p>We found the practice believed in continuity of care for patients and where possible would allow patients to book with a clinician of their choice. However, all staff we spoke to explained that if a matter was urgent, they would offer the patient a choice of an appointment with another clinician or at a different branch site sooner to ensure they received care in a timely manner. Reception staff also explained they would offer this if there was a long delay for a routine appointment.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.00 am – 12.45 pm and 2.00 pm – 6.00 pm
Tuesday	8.00 am – 12.45 pm and 2.00 pm – 6.00 pm
Wednesday	8.00 am – 12.45 pm and 2.00 pm – 6.00 pm
Thursday	8.00 am – 12.45 pm and 2.00 pm – 6.00 pm
Friday	8.00 am – 12.45 pm and 2.00 pm – 6.00 pm
Appointments available:	
Monday	8.00 am – 12.45 pm and 2.00 pm – 6.00 pm
Tuesday	8.00 am – 12.45 pm and 2.00 pm – 6.00 pm
Wednesday	8.00 am – 12.45 pm and 2.00 pm – 6.00 pm
Thursday	8.00 am – 12.45 pm and 2.00 pm – 6.00 pm
Friday	8.00 am – 12.45 pm and 2.00 pm – 6.00 pm

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

- Patients could also access extended hours appointments on Saturday mornings between 8.30 am and 1.00 pm. These were provided by South Downs Health and Care (SDHC), which is an out of hours GP service contracted by the practice to deliver extended hours services including contraceptive implant fittings, GP, phlebotomy and cervical screening appointments.
- 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. These were provided by a paramedic employed by the practice who would attend the home of the patient and assess the patient. Where the paramedic needed advice or guidance, they would refer to the patient to a GP and if necessary, a further home visit would be completed.
- There was a medicines delivery service for housebound patients. This was provided to eligible patients via the dispensary at the Ninfield Surgery.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice offered community dermatology and microsuction services and contraception services to patients from other surgeries.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <p>During the inspection we checked the availability of appointments and found patients could access appointments in a timely manner. For example, we found:</p> <ul style="list-style-type: none"> • The next prebookable face to face GP appointment was available 2 days after the site visit. • The next prebookable telephone GP appointment was available the day after the site visit • There was a cervical screening appointment available on the day of the site visit and another 2 days after the site visit. • The next prebookable routine nurse appointment was available 2 days after the site visit, however the cervical screening appointment could be converted to a routine appointment if required and to prevent it not being used. <p>Due to patient feedback including comments about access to appointments and queues when calling the practice, we asked the practice about any changes they had made to improve access for patients. We found the practice had taken part in an NHS funded improvement project called the Accelerate programme. The purpose of the programme was to look at the patient flow through the practice to try and improve the experience for both patients and staff. Three key changes had resulted from this programme.</p> <ul style="list-style-type: none"> • The practice had changed their appointment system to a system call 'Total Triage' this meant that all urgent, on the day requests, needed to be made by a specified cut off time. A GP would continually triage the requests to determine the response required and gave administrators clear direction on how to respond to the patient. For example, booking an appointment that day or a routine appointment in the future. If the future appointment was not convenient, the patient could contact the practice to change the time or date. This system had only been introduced very recently but reception staff reported they had received less negative feedback about the availability of appointments, and we were told the GPs were finding the new system more effective. • The practice had consolidated their telephone contact numbers into 2 numbers, instead of 1 per branch. This meant that reception staff at all sites could support with answering the phones at times of peak demand. The reason for keeping a separate number for the Ninfield Surgery was because the branch had a dispensary and the practice wanted patients to be able to direct specific queries to the dispensary. • The practice had combined all their telephony services into a single contract for a cloud-based system which allowed them to monitor the number of calls waiting, average length of a call and the average wait-time for patients. There were additional functions within the system that the practice believed would benefit patients and make access simpler but at the time of the inspection were being explored and were not in use. 	

These changes were very recent, and the practice had not completed analysis yet to establish whether the changes had resulted in improvements, however staff feedback and some of the patient feedback we received during the inspection indicated the changes had been well received.

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 (01/01/2022 to 30/04/2022)	77.3%	N/A	52.7%	Variation (positive)
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)	72.3%	56.3%	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)	73.8%	54.1%	55.2%	Tending towards variation (positive)
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)	85.8%	75.0%	71.9%	Tending towards variation (positive)

Source	Feedback
NHS.uk website (formerly NHS Choices)	We reviewed 5 pieces of feedback on the NHS website, and all provided 5-star ratings for the practice. 1 piece of feedback specifically commented about how well the new total triage service had worked for that patient. Another piece of feedback commented about how quickly an online consultation request had been responded to and other feedback commented about how confident patients were with the service. All feedback had been acknowledged by the practice.

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.	44
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.	P
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed a sample of 3 complaints during the inspection. We found all had been acknowledged by the practice in a timely manner and all demonstrated the practice had investigated the complaint, listened to the patients concern and, where appropriate, had apologised or made changes as a result. We also found staff were clear about how to support patients to complain if they had a concern.</p> <p>The practice maintained a record of all the complaints received which included criteria such as whether the complaint was clinical or non-clinical in nature, required an incident report to be completed and whether the complaint was upheld. However, it did not include themes or key points from the complaint to allow the practice to complete any analysis of trends. We identified a theme of patients complaining about reception staff being rude or unhelpful and discussed this with the practice. It was confirmed the practice was aware several complaints had been made but in mitigation, management explained they were able to overhear conversations in reception and felt that at times patients were also rude towards reception staff, so they wanted to be balanced in their response. However, to support staff and patients they told us training was planned for the team.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient complained that they did not feel the information given to them about their medicine was clear and they did not feel it was appropriate for a member of staff to give their personal experience as advice.	The practice acknowledged the complaint, investigated the concern, clarified the information for the patient, and gave the patient an apology that the information given had not been clear enough. The apology was accepted.

Well-led

Rating: Inadequate

We have rated the practice inadequate for providing well-led services because we found:

- Governance systems and processes existed but were not effective or operated consistently across the whole practice.
- Governance systems did not always provide leadership and management with accurate and up to date information.
- Where data and information indicated performance issues, we found examples where action was not taken promptly or at all and responses were not effective.
- We were not assured that when changes were made, they were planned appropriately or monitored and reviewed once undertaken.
- Action was required to ensure teams operating across multiple sites supported each other and worked effectively.
- Roles and responsibilities and systems of accountability were not always clear to staff or clearly understood.
- Not all staff were confident there was a clear vision for the future of the practice and not all staff felt involved in the development of the strategy for the future.

Leadership capacity and capability

There was compassionate and inclusive leadership however, the leadership did not demonstrate it 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.	P
They had identified the actions necessary to address these challenges.	P
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Our inspection found the practice was aware of the challenges faced by primary care, both generally and specifically to the practice and the practice had plans to respond to examples given, For example:</p> <ul style="list-style-type: none"> • The practice needed new premises that were suitable for a modern GP practice and the increasing number of services provided in primary care. We found the practice was actively progressing plans to move to new premises. • The practice was also aware of the national staffing crisis in healthcare, particularly in clinical roles such as GPs and nurses. The practice was a GP training practice to help create a pipeline of staff for the future. The practice had successfully recruited 2 GP registrars that were currently training at the practice and had also recruited 2 new nurses in the last 6 months. <p>However, we also found that although the merger of the 2 practices had been completed in July 2021, nearly 2 years ago, the merging of teams, systems and processes had not progressed as quickly as expected in all areas. For example, some teams were more supportive of each other than others when they worked across different sites and some staff spoke of working at certain branches or of their old practice, rather than of being part of a new single practice. In mitigation, we were told by leaders that they were aware of this and in response they had held a practice event to improve team relations and communication across the practice. However, to understand whether the practice understood the challenge of merging and how this had been</p>	

planned, we asked whether there had been a merger plan to identify all the systems and processes that needed to be merged into a single new practice. We were not shown evidence of a formal plan during the inspection but afterwards the practice explained the NHS Accelerate programme they had taken part in had focused on creating a vision for the practices' future and aligning processes as well as improving patient flow. However, we found that governance systems and processes were not fully developed, completely embedded, or operating consistently across the whole practice.

Vision and strategy

The practice had a clear vision to provide high quality sustainable care, but there was limited evidence of a strategy to achieve the vision.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	P
Staff knew and understood the vision, values and strategy and their role in achieving them.	P
Progress against delivery of the strategy was monitored.	P
<p>Explanation of any answers and additional evidence: The practice understood the roles of stakeholders including staff, patients and external partners. However, we found that while staff understood the merger had been necessary to ensure the practice could continue to provide sustainable care to its patients, not all staff, across all sites felt they were involved in developing the vision and strategy for the future of the practice. This meant leadership and management had needed to take action to improve communication and team working across the practice. In response the practice had organised events to amalgamate all the staff and the processes into the new practice.</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.	P
Staff had undertaken equality and diversity training.	Y

Explanation of any answers and additional evidence:

Staff feedback was extremely positive about how supportive leadership and management were towards professional development, personal concerns and, many staff reported there was an open-door approach which encouraged conversations about these matters.

Staff we spoke with spoke positively about how they just wanted to achieve the best outcomes for the patients and how they would try and be as flexible as they could to achieve what the patient needed. We found evidence of this approach in the feedback received from patients.

All staff we spoke with confirmed they would feel comfortable to raise a concern with leadership or management without fear of any retribution, and were confident that action would be taken, if appropriate and necessary.

The practice had access to a Freedom to Speak Up Guardian who was external to the practice, so staff could raise concerns under the whistleblowing policy. However, not all staff we spoke with knew who this person was. In mitigation, those staff told us they knew how to find the policy and spoke of other external organisations they would approach if they needed to raise concerns.

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

Source	Feedback
Staff feedback	This member of staff told us they felt well supported, that change happened when concerns were raised by patients and, communication within the practice had improved.
Staff feedback	This member of staff told us there was a kind, supportive culture within the practice and they had been supported with specific issues. However, they felt it would be helpful to have more clinical meetings.
Staff feedback	This member of staff told us there was a good team that worked well together, and that management had an open-door policy. However, they also told us they hoped there was a clear vision for the future, and they had not been involved in developing the mission statement and values of the practice.

Governance arrangements

The overall governance arrangements were ineffective because responsibilities, roles and systems of accountability to support good governance and management were not clear or overseen effectively.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
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
<p>Explanation of any answers and additional evidence: Although we found governance structures existed, we found examples where these were either ineffective or were not consistently operating effectively. For example:</p> <ul style="list-style-type: none"> • The practice did not have a policy which specified the mandatory training the practice required staff to complete. We also found the practice's systems and processes to record training completed by staff were not effective because the system did not hold an accurate training record for staff. This meant leadership and management did not have completed oversight of staffs' training and whether they had the required or up to date knowledge and skills to perform their roles. In mitigation, we found evidence this had been identified by management and there were some actions decided to improve the system, but they were not being progressed promptly. • We found improvement had been made to the system to respond to patient safety alerts and medicines recalls from the Medicines Healthcare products Regulatory Agency (MHRA) because there was a system to receive and share alerts when received and a log of action taken in response to the alert. However, the practice system was not completely effective because it did not include all historic alerts and we did not find evidence that searches for patients affected by alerts were carried out routinely. The historic alerts which were not included in the practice's processes had not been identified through reviews of clinical governance. After the inspection the practice confirmed that there was a process to run repeat searches, however we were not provided with additional evidence to demonstrate this so were unable to confirm this process was embedded or operational. • We found health and safety risk assessments had been completed but contained recommendations to lower or remove risks to the safety of the premises. It was not always clear whether the recommendation had been undertaken or if it had not, the reason for not doing this was not documented with control measures to manage the risk. • We found the management of infection prevention and control (IPC) was not effective because IPC leads had not completed specialist training for this role. Audits had been completed and, in some cases, they contained actions plans to reduce the risk of the spread of infection whereas in others they did not. We also found decisions about actions had been made but had not been documented. This meant it was not clear which actions were completed and which were outstanding. • We found there was a system to monitor the stock of emergency medicines and their expiry dates, however, we found an example where this system had not worked because we found an expired medicine at 1 site. In mitigation, the practice acted immediately by removing it from the stock and obtaining a replacement that day. • We did not find there was a system to monitor the expiration dates of emergency medical equipment. At 1 site we found an adult oxygen mask had expired and was still in use in the practice. 	

- We found there was a system to record significant events that occurred in the practice. However, the evidence we saw showed the events that had been recorded were clinical incidents and there was a non-clinical incident which could have been recorded and used to share learning within the practice.
- We found there was not a consistent approach to documenting checks of staff's registrations with supervisory bodies because, of the 3 clinical staff we sampled, we only found evidence this had been checked for 2 GPs but not for a nurse. We also did not find evidence of references for 2 clinical staff.

Overall, the practice did not have effective oversight of all their governance systems and processes to ensure they were effective, operating consistently or as intended. We also found roles and responsibilities were not always clear or clearly understood, and accountability was limited.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

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

Clinical audits were completed to improve performance in the care for patients. However, clinical governance had not identified the practice system and process to respond to patient safety alerts from the MHRA did not provide a completely effective response to the risk.

At this inspection we found the practice did not have effective systems to identify and record risks and when risks were identified the action taken to monitor, manage or mitigate them was not always an effective response. For example, the practice did not operate a risk register or another system to provide leadership and management with complete oversight of ongoing risks faced by the practice or assurance that these were being effectively managed or mitigated. This could have given greater assurance that were effectively controlled, for example health and safety premises risks and IPC risks.

Where risks were identified we did not find the practice had documented a risk assessment to establish the scale of the risk or impact and the necessary control measures to manage the risk. For example, the system and process to monitor staff vaccinations did not follow national guidance and the practice did not have complete records of staffs' vaccinations. We were provided with mitigation that the practice was aware and had requested this information from staff, however, we were not shown a risk assessment that considered the risk to patients and staff from contracting communicable diseases.

We also found opportunities to improve the quality of care for patients existed and were provided some assurance that action was being taken, however, we were not shown evidence this had been formally recorded with an action plan to achieve the improvement. This meant opportunities to improve the systems and

processes to effectively manage clinical governance risks existed. For example, when we highlighted the 442 patients with a potential missed diagnosis of chronic kidney disease (CKD) stages 3, 4 or 5 to the practice, we found they were aware and had already completed research and created internal guidance, but we were not shown evidence the risk had been formally documented or discussed or that there was an action plan to complete the improvement required.

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	P
Performance information was used to hold staff and management to account.	P
Staff whose responsibilities included making statutory notifications understood what this entailed.	P
<p>Explanation of any answers and additional evidence:</p> <p>Opportunities to use data to measure performance and hold staff and management to account existed but were not fully utilised. For example, the practice had not completed its own patient survey to understand the experience of patients and areas where the practice could improve. Therefore, while the changes made to the appointment booking process and phone system appeared to have delivered improvement based on staff and patient feedback, other areas may have required improvement more urgently and were not identified. Another example where data could have been used to hold teams or individuals to account was the complaints process. While the complaints log included a summary of the complaint, outcome and staff group involved, theme or trend analysis and volume of complaints was not present in the log and this information could have been used to evidence action taken by the practice in response to identified performance concerns for the benefit of patients.</p> <p>However, in mitigation, we found evidence of an access improvement plan which had been completed in conjunction with other practices in the Bexhill PCN. This used data and other information to assess the access performance at the 3 practices in the PCN and identify opportunities for improvement. It also demonstrated that the practice contributed to initiatives and opportunities where data could be used to improve performance.</p> <p>After the inspection the practice provided examples of internal and external data that was monitored. However, we were not provided evidence of how this was used to improve performance or of the impact of this process.</p> <p>During the inspection process we heard of an incident which required a statutory notification to be submitted to the Care Quality Commission (CQC), however, this notification had not been completed by the practice. We also identified inaccuracies in the practices' registration with the CQC, however, in mitigation, once identified to the practice the applications to make the registration accurate were completed immediately.</p>	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	P
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence: The practice had not completed a patient survey recently, however, we were told patient feedback was sought on a continual basis and used to inform changes at the practice. We saw evidence of patient feedback opportunities at the sites we visited. An example of patient feedback being used to improve services was the Total Triage appointment request system which had resulted partly from patient feedback about access to services but also from staff feedback and the Accelerate improvement programme the practice had participated in.</p>	

Feedback from the Patient Participation Group

We spoke with a member of the Patient Participation Group (PPG) and found they felt the practice valued the PPG and gave honest and transparent answers when concerns or feedback were raised. The PPG member told us that the group had been used to share information and initiatives with patients and when the PCN had held a patient awareness event, the group had supported the delivery of the event on the day. This member of the PPG was very happy with their experience of care at the practice.

Continuous improvement and innovation

There was evidence of systems and processes to support learning and improvement.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	P
Explanation of any answers and additional evidence: We found examples of activity which demonstrated the practice valued learning and improvement, for example: <ul style="list-style-type: none">• The practice had embraced the opportunity to participate in the Accelerate Programme to improve patient flow through the practice.• We also heard of examples where the practice had or was supporting staff to develop their careers by completing further qualifications. For example, a healthcare assistant was being supported to become a trainee nurse associate.• The practice had supported a paramedic practitioner to complete a further qualification and was supporting another paramedic to complete the same qualification.• The practice was committed to training future GPs and had 3 registered GP Educational supervisors.• The practice had shared the learning from the audit focused on preventing cardiovascular disease in patients with diabetes with external stakeholders and was committed to sharing it more widely to educate more clinicians.• The practice told us they had organised teaching events in areas such as dermatology and cardiology. Neighbouring GP practices had been invited to attend these sessions.	

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 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.