

## Inspection Evidence Table

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(1-2715509380)

**Inspection Date: 20 April 2023**

Date of data download: 14/04/2023

## Overall rating: Good

### Safe

### Rating: Good

At our last inspection on 12 November 2021, we rated the practice as inadequate for providing safe services because systems for monitoring patients prescribed high risk medicines were not safe or effective. Patients did not always receive appropriate physical health monitoring and treatment in accordance with national guidance.

The practice had made improvements to comply with the regulations when we undertook a focused inspection on 11 March 2022. Action had been taken on the medicine management issues identified at the previous inspection.

**The practice is now rated Good for providing safe services.**

At this inspection, we found the practice had sustained the improvements made and there was evidence of safe care, for example:

- *We saw evidence that the practice had sustained improvements identified at our last inspection. Patients had received appropriate physical health monitoring and treatment in accordance with national guidance.*
- *The system of medicines reviews for patients with long term conditions had improved. For example, systems to review physical health monitoring with appropriate follow-up were consistently implemented.*
- *The practice had a clear system to ensure oversight of safe prescribing. For example, leaders checked that clinicians were following the prescribing protocol to ensure appropriate monitoring has been carried out prior to prescribing. The practice had also established a monthly audit of prescribing.*

### Safety systems and processes

**The practice had improved 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 <sup>1</sup>
Partners and staff were trained to appropriate levels for their role.	P <sup>2</sup>
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> <ol style="list-style-type: none"> <li>1. Staff we spoke to knew who the safeguarding leads were. We were informed there was a lead for adults and a lead for children. Staff knew where to find the practice safeguarding policies which contained information about who the practice safeguarding leads were. The provider was the safeguarding lead at the practice. The practice had appointed a non-clinical safeguarding lead who carried out administration of safeguarding documents and tasks.</li> <li>2. At this inspection we checked the staff mandatory training log and reviewed staff files. One non-clinical member of staff had not completed mandatory adult safeguarding training at the level required for their role. Although they had completed adult safeguarding level one, the member of staff had not completed level two adult safeguarding. We spoke with the practice manager and immediately following our inspection, the practice sent us evidence of the staff member's completed adult safeguarding training. We saw from the mandatory training log that all other staff had completed levels one to three adult and child safeguard training. All clinicians had completed their adult and children's safeguarding training to level three.</li> </ol> <p>A review of patient records found the practice had a system to highlight vulnerable adults and children on patient records and also a register. The practice followed up children of concern if they did not attend their appointment.</p>	

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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y <sup>1</sup>
Date of last assessment: 30/08/2022 completed by NHS Property Services Ltd	Y
There was a fire procedure.	Y
Date of fire risk assessment: 22/02/2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1. Although the practice did not manage the building, the provider had a programme of health and safety risk assessment and had a system to assure themselves that the premises were safe to use for their intended purpose and was used in a safe way.</p> <p>The provider was able to submit a current health and safety risk assessment regarding the part of the premises the provider occupied. The practice building was owned by NHS Property Services Ltd (NHSPS), and they were responsible for the upkeep and maintenance of the building. The most recent fire risk assessment was carried out by NHSPS on 22 February 2023, and we found any actions had timescales for completion. The provider had an overview of the relevant building checks. For example:</p> <p>Fire extinguishers were last serviced on 20/07/2021  Fire drills were undertaken annually by the provider. The last fire drill was 20/01/2023  Fire alarm testing checks were carried out each month by NHSPS  PAT testing date 07/07/2022  Equipment calibration date 07/07/2022  Legionella risk assessment 27/03/2023 completed by NHSPS  COSHH risk assessment 10/01/2022 completed by NHSPS</p>	

### Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 13/04/2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence:	

## Information to deliver safe care and treatment

**Staff had the information they needed to deliver safe care and treatment. Clinical oversight of risks associated with the management of test results had improved.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. 1	Y <sup>1</sup>
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.	P <sup>2</sup>
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 <sup>3</sup>
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y <sup>4</sup>
Explanation of any answers and additional evidence:	
<p>1. At our inspection in November 2021, the provider did not have effective processes to ensure all clinicians documented that they had looked at monitoring results and determined it was safe to prescribe. While we were assured that the test results were available to be reviewed, we found examples where there was no indication in a patient's clinical records that the results of tests were considered as part of a medicine review. At this inspection, managers had embedded systems to ensure oversight of prescribing. Our review of patient records in relation to the clinical searches identified that care records were managed in a way that protected patients. For example, history, examination, management plans, safety netting and follow up were adequately documented within the patient record.</p>	

- At this inspection, the provider did not always have oversight of systems that manage information about people who use services. For example, we reviewed the EMIS workflow manager system and while we found the practice was up to date with Lab Reports and Medicines Management workflow items, there were a large number of pathology tasks which appeared not to have been completed. It was not clear whether managers had global access to the EMIS Task Management system. We identified 1,565 actioned tasks sitting in the global inbox and staff had not clicked complete. When we looked at the Task Management To-Do list we saw that a task had been actioned but the staff member had not clicked completed.

We checked a small sample of records and were assured that the relevant task had been done but staff had not clicked task completed. We discussed the action we required the practice to take with the GP lead. They agreed to do a dip sampling of two patient records for each month in the last 12 months, to make sure the tasks had been done. The lead GP provided us with a printout of a sample of 24 patient records showing the relevant tasks had been completed.

The lead GP shared a summary of their plan to develop a process for making sure tasks were completed by all staff. The provider arranged for the GP Partners to have global access to the task manager to monitor the to-do list more effectively. Following our inspection, managers scheduled a meeting with practice staff, including the pharmacist and coders to demonstrate how a task should be completed on the EMIS system when it has actually been done. The operations manager would monitor any escalated task workflows, as well as giving the GP Partners global access.

- At our previous inspection in November 2021, although the practice had a documented approach to manage test results, we found it had not been implemented effectively. At this inspection, there was evidence that clinicians had reviewed test results in a timely way and had ensured monitoring results, which may alter patient management, were acted on.
- At this inspection, managers had implemented a call and recall protocol to ensure patients who take certain medicines which require monitoring were followed up in a timely way. Staff we spoke to were aware of their responsibilities for managing test results. There was a clear process for non-clinical staff to follow when test results were received.

### Appropriate and safe use of medicines

**The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. The practice had effective systems to ensure that patients prescribed high risk medicines were being monitored appropriately, in line with current guidelines.**

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	0.59	0.64	0.86	Variation (positive)

Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)				
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)	6.1%	8.3%	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)	4.89	5.52	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	67.3‰	73.2‰	130.3‰	Tending towards variation (positive)
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)	0.24	0.37	0.56	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	3.8‰	4.7‰	6.8‰	Tending towards variation (positive)

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. 1	Y <sup>1</sup>
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	Y <sup>2</sup>
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y

There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence, including from clinical searches.	
<p><b>Medicine reviews</b></p> <p>1. At our previous inspection in November 2021, although the practice had a written protocol for repeat prescribing of medicines which needed monitoring, clinicians had not followed the protocol to ensure appropriate monitoring and prescribing had been carried out. This meant patients' records were at risk of being incomplete which potentially could put patients at risk of not being appropriately re-called, followed up, and reviewed. At this inspection, our clinical review of patient records showed patients were having blood tests arranged and clinicians were routinely recording that these indicated it was safe to continue prescribing medicines. The provider had taken action to embed the improvements we identified at our focused inspection on 11 March 2022. For example:</p> <ul style="list-style-type: none"> <li>• At this inspection, we discussed the findings from the records review with the lead GP who told us that patients who require blood tests or who are due for review are sent a letter from the patient's doctor encouraging them to attend for a blood test. The practice had a call and recall protocol. Staff used a spreadsheet to record telephone calls to patients and whether contact had been made. Staff could book the patient in for a medicine review and the required blood tests. Clinicians also sent tasks to staff about individual patients who needed to come in for blood tests and medicine reviews. The lead GP told us that the pharmacist supports the practice by doing remote medicine reviews with patients, where appropriate.</li> <li>• At this inspection, the provider had implemented monthly audits of prescribing at the surgery. This was completed by the practice pharmacist who audited a sample of patient records to check that when prescribing, clinicians had checked that bloods were up to date or that the patient had been advised to come in for blood tests. The audit also checked that medicine reviews were up to date, that interactions with other medicines were considered when prescribing and that the prescribed medicine was in line with the prescribing policy. We found that the provider had oversight of the prescribing audit carried out by the pharmacist.</li> </ul>	

## Medicines monitoring: High-risk medicines

2. Although the majority of patients on high-risk medicines whose records we looked at had appropriate monitoring completed there were a small number of patients whose monitoring was overdue. However, after reviewing these patient records, we considered the risks associated with monitoring these patients to be low. For example, during our clinical review of patient records we found:

- Two patients prescribed Warfarin had not had monitoring tests in last 3 months. The patients were being monitored by the anticoagulant service in hospital but there was no note of the INR result in the patients' record. It was unclear from the records that the prescriber checked monitoring was up to date prior to issuing a prescription or when the next INR test was due.

We spoke with the lead GP who immediately checked the local care record and confirmed that monitoring was up to date and the two patients had received INR tests. We were assured that patients prescribed Warfarin were receiving the appropriate monitoring for their condition at the correct frequency.

- When we discussed our findings with the provider, we also asked how they review test results when monitoring had happened in secondary care. They informed us that the clinician would access and check the local hospital system to see if the required blood tests have been performed via a patient report link. The clinician should then manually enter the data with correct test date and results into the patient record on EMIS.
- We looked at 21 patients taking methotrexate (a medicine used to suppress the immune system) and all had the required monitoring in the last six months. The patients had appropriate blood, liver and kidney tests to ensure that these medicines were safe to prescribe.

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y <sup>1</sup>
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	13
Number of events that required action:	Y
Explanation of any answers and additional evidence:	



1. There was a policy for management of significant events. Staff confirmed significant events and learning were discussed at staff meetings or followed up individually when appropriate. We were provided with the minutes of two team meetings which included a discussion regarding incidents and significant events.

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

Event	Specific action taken
An E-consult was added incorrectly to a patients file. This led to the wrong patient being called. This was caused by the patient sharing the same name with a family member.	Staff flagged the issue that both members of the family have the same names. A pop-up alert now prompts staff to check the date of birth against the NHS numbers. Learning outcome was to make sure staff always used the NHS number first to cross reference.
A urine sample was placed in the wrong transport bag. Practice received letter via post from Cervical Screening London advising a non-cervical screening (urine) sample included in their courier transport bag.	Make sure all staff are aware of the correct bags for the appropriate samples. Practice staff acted by dividing the different coloured courier bags in reception area and discussed learning with staff. The incident was discussed in the practice team meeting and learning recorded and shared in minutes.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. 1	Y <sup>1</sup>
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1. At our previous inspection in November 2021 the practice could not demonstrate that Medicines and Healthcare products Regulatory Agency (MHRA) alerts were being actioned appropriately. During our inspection in March 2022, we reviewed the records of patients taking citalopram and found that the provider had reviewed and managed these patients appropriately. At this inspection, the practice had taken action on recent safety alerts for example, we reviewed the records of three patients taking citalopram (a medicine used to treat depression), and found that the provider had reviewed and managed these patients appropriately. For example, we found a record of discussion of risks was documented before the prescription was issued for these patients. Staff showed us the web-based platform used to log MHRA/CAS safety alerts and log what action was taken. We saw that all relevant safety alerts had been responded to. We saw evidence of safety alerts discussed and reviewed in weekly clinical team meetings.</p>	

## Effective

## Rating: Good

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

At our last inspection on 12 November 2021, we rated the practice as requires improvement for providing effective services because the provider did not have effective systems in place to review monitoring appropriately. Childhood immunisation uptake rates were still below the World Health Organisation (WHO) targets. Cervical screening achievement which was lower than CCG and England averages.

The practice had made improvements to comply with the regulations when we undertook a focused inspection on 11 March 2022. Action had been taken on the medicine management issues identified at the previous inspection.

### **The practice is now rated Good for providing Effective services.**

At this inspection, we found the practice had sustained most of the improvements made and there was evidence of delivery of effective care, however the practice was yet to demonstrate it had an effective strategy to improve their performance for cervical screening and childhood immunisation;

- *We found patients immediate and ongoing needs were fully assessed and diagnosed.*
- *The practice had implemented a call and recall protocol, and this was effective in ensuring patients with chronic diseases and patients with long term conditions, were followed up in an appropriate and timely way.*
- *Childhood immunisation uptake rates were still below the World Health Organisation (WHO) targets. Uptake rates for the vaccines given were below the target of 95% in all of the five areas where childhood immunisations are measured.*
- *The practice had not demonstrated it had an effective strategy to improve their performance for cervical screening which was lower than CCG and England averages.*
- *Further work was required to understand the lower cancer indicators against the local clinical commissioning group and England average data.*
- *There was evidence of improvements made through quality improvement activities.*

**Effective needs assessment, care and treatment**

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y <sup>1</sup>
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> <ol style="list-style-type: none"> <li>At our previous inspection in November 2021 although staff had access to local and national guidelines they had not always used this information to deliver care and treatment that met patients' needs. The provider did not have effective processes to ensure all clinicians documented that they had looked at a patient's monitoring results and determined it was safe to prescribe. This meant patients were not always receiving appropriate treatment and monitoring for their conditions. At this inspection, our clinical review of patient records showed patients were having blood tests arranged and clinicians were routinely recording that these indicated it was safe to continue prescribing medicines. The provider had taken action to embed the improvements we identified at our focused inspection on 11 March 2022.</li> </ol>	

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. At this inspection, patients had received appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. We spoke to staff who told us the practice had a call and recall system in place. The practice ran Ardens searches of the clinical records and lists of patients for call and recall were given to members of the admin team to work from. For example, a list of patients to call to have their blood pressure check. The clinical lead was responsible for oversight of the system of call and recall. Clinicians also sent tasks about individual patients who needed to come in for reviews.
- The practice had recruited a nurse prescriber to support the management of patients with long term conditions. The nurse worked full time at the practice and had a special interest in preventative care. The practice had also recruited an additional HCA to support reviews of patients and carry out health checks.
- The practice kept a register of patients with a learning disability (LD) and there were alerts on medical records to help staff identify patients when they contacted the practice. All patients with a learning disability were offered an annual health check. There were 57 learning disability patients on the LD register with 37 health checks done and action plan completed in past 12 months.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The practice had a recall protocol for patients with diabetes, asthma, Chronic Obstructive Pulmonary Disease and patients with mental health disorders. The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice liaised with Pride in practice who support and advise on care of Transgender patients and give advice on gender Dysphoria.

## Management of people with long term conditions

### Findings

At our previous inspection in November 2021, the practice could not demonstrate that patients with a long-term condition were receiving appropriate medicine review in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. At this inspection, we reviewed a random sample of 14 patient records and found that all patients had their long-term condition managed in line with recommended guidance:

- The provider GP was responsible for reviews of patients with long-term conditions. A review of patient records demonstrated that the provider had carried out annual reviews of patients with long term conditions. For example, 99% of patients with diabetes had an annual review.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- The practice had the support of a pharmacist employed by their Primary Care Network, who supported the annual review of patient medication.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Patients with asthma were offered an asthma management plan.

Child Immunisation

Numerator

Denominator

Practice

Comparison  
to WHO target  
of 95%

The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	83	94	88.3%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	88	119	73.9%	Below 80% uptake
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)	92	119	77.3%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	91	119	76.5%	Below 80% uptake
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	80	118	67.8%	Below 80% uptake

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

### Any additional evidence or comments

At our last inspection in November 2021, the practice had not met the minimum 90% target for all five childhood immunisation uptake indicators (01/04/2019 to 31/03/2020). At this inspection the practice had still not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five childhood immunisation uptake indicators.

We asked the practice what they had done to improve uptake of childhood immunisations. The practice provided Open Exeter How am I driving data showing an improvement, however, this was not comparable data. The nationally comparable CHIS published data showed Childhood immunisation uptake rates were still below the World Health Organisation (WHO) targets of 80% uptake for four areas measured. The practice was just below the minimum target of 90% in one area (88.3% for age one three doses of DTaP/IPV/Hib/HepB);

- The percentage of children aged one who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) was 88.30% at 31 March 2022. However, the provider submitted unverified data which showed that, as at 31 March 2023, out of 83 eligible children, 76 had received their vaccination (92%).

- The percentage of children aged two who had received their booster immunisation for Pneumococcal infection was 73.95% at 31 March 2022. However, the provider submitted unverified data which showed that at 31/03/2023, 78% of eligible children had received their vaccination.
- The percentage of children aged two who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) was 77.31% at 31 March 2022. However, the provider submitted unverified data which showed that at 31/03/2023, 81% eligible children had received their vaccination.
- The percentage of children aged two who had received immunisation for measles, mumps and rubella (one dose of MMR) was 76.47% at 31 March 2022. However, the provider submitted unverified data which showed that as at 31 March 2023, 79% of eligible children had received their vaccination.
- The percentage of children aged five who had received immunisation for measles, mumps and rubella was 67.8% at 31 March 2022. However, the provider submitted unverified data which showed that as at 31 March 2023, 72% of eligible children had received their vaccination.

The practice had an action plan to improve uptake. For example;

- The practice had a call/recall protocol in place, for patients who were due childhood immunisations. The practice carried out monthly records searches for patients that were due immunisations and maintained records of patients that had been followed up.
- Staff worked from a spreadsheet of searches and called parents / guardians to book appointments; send reminder letters to parents / guardians who were not contactable by phone.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Staff told us the practice was working in collaboration with the local Integrated Care Board (ICB) to host an educational session for parents to attend.

Cancer Indicators	Practice	SICBL average	England	England comparison
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	27.1%	54.2%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	57.0%	60.5%	66.8%	N/A
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)	60.6%	50.9%	54.9%	No statistical variation
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (30/09/2022 to 30/09/2022) (UKHSA)	57.2%	N/A	80.0%	Below 70% uptake

**Any additional evidence or comments**

- Some of cancer screening indicators, specifically breast and bowel cancer screening, for the practice were relatively lower than national averages. At the previous inspection in November 2021, we found two-week wait cancer referrals data were lower than national averages. At this inspection the data has remained lower than the local Care Commissioning Group and National Average. Although, this number could have been affected by the effects of the pandemic. We asked the practice if they were aware of its outliers in terms of breast and bowel cancer screening? The practice told us they had discussed the low take up during their clinical team meetings that the practice was taking active steps to increase uptake.
- As shown above, in 2022 the practice was below the 80% coverage target for the national cervical screening programme (as measured by Public Health England). We asked the practice what they had done about low uptake to encourage greater coverage.
  - The practice told us they had discussed the low scores during their clinical team meetings and had taken action to follow up all women who had not had cervical screening.
  - The practice had recruited a practice nurse who was targeting the uptake of cervical screening. The sample taker audited their inadequate cytology rates and had a system of follow up to recall patients for a second test.
  - The practice had started to use Ardens patient record software to run searches and staff contacted patients and invited all those overdue cervical screening to make an appointment.
  - All non-attenders were flagged on the medical records and the nurse told us that she personally called all patients who did not attend to have a further discussion. Screening was also offered opportunistically to patients.
  - The practice told us they planned to organise an educational session for patients using videoconference to engage with non-responders from hard-to-reach groups.
- Unvalidated data at 31 March 2023, indicated an improvement in smear achievement. Data shared by the provider indicated the practice had achieved 62.37% uptake for women aged 25 to 49, and 81.06% for women aged 50 to 64.

**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. There was evidence of activity aimed at improving the quality of clinical care, since our last inspection.**

	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



- We saw that the practice had undertaken a range of two cycle audits which demonstrated quality improvement for patients, for example an audit of primary prevention with intervention for high Cholesterol with Q risk2  $\geq 10$  and Allopurinol use in Gout management.

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	P <sup>1</sup>
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y <sup>2</sup>
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> <ol style="list-style-type: none"> <li>1. At this inspection, we reviewed the staff training log and found there were some gaps in mandatory training for staff. For example, fire safety training was overdue for the GP partner and one non-clinical member of staff had last completed IPC training in 2016. There was a system to track when mandatory training was due, however this process was not effective in monitoring the training that all staff needed to complete to ensure they demonstrated the skills and competence to fulfil their role. <p>When we spoke to staff they told us that managers used an online platform to track mandatory training. Staff told us that managers received notifications when training was due to expire. At this inspection we found managers were not always receiving notifications alerting them that training modules were due to expire.</p> <p>Immediately following our inspection, the practice sent us evidence of completed fire safety training by the GP partner and evidence of completed IPC training by the non-clinical member of staff. We asked managers to review the online training platform to ensure staff received email alerts about modules due to expire.</p> </li> <li>2. The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. We looked at</li> </ol>	

staff files and found evidence of checks of the relevant professional register to ensure staff prescribed within their clinical competence. The partners audited the prescribing of the advanced nurse practitioner and practice pharmacist to check that prescribing was appropriate and that staff followed best practice guidance. We spoke to the practice pharmacist who shared a copy of the template used to audit their recording of consultations.

### 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
Explanation of any answers and additional evidence:	

### 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:	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Y <sup>1</sup>
1. We reviewed a sample of individual care plans of patients who have had a Do not attempt cardiopulmonary resuscitation (DNACPR). Our clinical review of notes where a DNACPR decision had been recorded, identified that where possible the patients views had been sought and respected. There was a record of discussion of the DNACPR decision in the clinical notes for the three patients we checked. We saw that information had been shared with relevant agencies.	

## Caring

## Rating: Good

At the last inspection in November 2021, we rated Caring as requires Good because the practice results for the national GP patient survey were still slightly below local and national averages, however the practice had taken action in response to the national GP survey and had undertaken their own survey.

### At this inspection we rated Caring as good because;

- *The practice's GP patient survey (GPPS) results for 2022 were still below local and national averages for most questions relating to kindness, respect and compassion from clinicians. Overall experience of the practice had decreased slightly from 59% (March 2021) to 53% (March 2022). However, there was evidence the practice had taken action to improve patient experience.*
- *We received positive feedback about the changes being made to address patient's concerns through responses from the patient participation group (PPG).*

## 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
Explanation of any answers and additional evidence:	

Patient feedback	
Source	Feedback
Patient Participation Group (PPG)	We spoke with one member of the patient participation group who told us that most of the practice staff were caring and that partners were responsive to patient feedback. The practice had recently worked with the PPG to publish it's first PPG Newsletter.

### 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)	83.5%	82.7%	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)	76.3%	80.5%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	90.3%	92.2%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	52.8%	69.3%	72.4%	Tending towards variation (negative)

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The percentage of people who stated that at their last appointment, the healthcare professional was good or very good at listening to them was in line with the CCG and national averages. However, patients who responded positively to the overall experience of their GP practice was below the CCG and national averages at 53%.</li> </ul> <p>At this inspection we asked the practice what action has been taken to address patient feedback scores that were lower than local or national averages. The partners and practice manager were aware of the 2022 national GP patient survey results and described the steps they had taken to improve patient</p>

experience. For example, the practice had introduced monthly all-day Saturday Clinics. The practice had increased staffing capacity by recruiting a full-time salaried GP. The practice had also employed a full time Advanced Nurse Practitioner to support the provision of same day emergency care.

Staff told us the practice continued to implement the learning from the 2022 survey results. At this inspection there was a system in place to discuss comments and complaints from patients during weekly clinical meetings, in order to improve service provision.

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

### 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 <sup>1</sup>
Explanation of any answers and additional evidence: 1. The practice supported and signposted patients to the most appropriate service to meet their needs. Staff supported patients through referrals to the Primary Care Network (PCN) social prescriber. This included giving patients details of services such as smoking cessation, eye care, sexual health, urgent dental care and health and social care support services.	

### 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)	87.7%	88.7%	89.9%	No statistical variation
<b>Any additional evidence or comments</b>				

The percentage of respondents to the GP patient survey who responded positively to being involved in decisions about their care and treatment was in line with CCG and national averages but had decreased slightly from 89% (March 2021).

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

Carers	Narrative
Percentage and number of carers identified.	The practice proactively identified patients who were carers. The practice had identified 813 patients as carers (6.97% of the practice list). Carers were identified through new patient health checks when staff asked patients if they were a carer. Staff also told us they identified carers opportunistically.
How the practice supported carers (including young carers).	Staff told us they made referrals to the PCN social prescriber who could contact the carer and advise about local carers services. Carers are coded on the practice patient records. The practice offered carers flexible appointment times and invited them to a carer's health check with the GP and for annual influenza vaccinations.
How the practice supported recently bereaved patients.	Staff told us they provided support and signposting to specialist bereavement services. Reception staff where appropriate would also ask families if they needed additional 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
Explanation of any answers and additional evidence:	

## Responsive

## Rating: Good

At the previous inspection in November 2021 we rated Responsive as good because although the practice results for the national GP patient survey were still slightly below local and national averages, the practice had acted on patient feedback.

### At this inspection we rated Responsive as good because:

- *Although GP patient survey results to questions about access to care and treatment remained below local and national averages, the practice had taken steps to address the access issues reflected by the GP patient survey. For example, staff told us that since our last inspection, they had taken action to audit live call monitoring features. Patient satisfaction with getting through to the practice on the phone had declined from 59% (March 2021) to 40% (April 2022).*
- *The practice still scored below the national average in the National GP Patient Survey in relation to how easy it was to get through to someone at their GP practice on the phone. The practice were aware of this and had an action plan in place to address lower scoring areas in the NHS national patient survey. There was evidence to support waiting times on the phone had improved.*

### Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	Time
Opening times:	

Monday	8.00am to 6.30pm
Tuesday	8.00am to 6.30pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 6.30pm
Friday	8.00am to 6.30pm
Appointments available:	
Monday	7.00am to 6.30pm
Tuesday	8.00am to 7.00pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 6.30pm
Friday	8.00am to 6.30pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. Receptionist were trained to know how to prioritise a patient if there was a flag on the clinical system.
- The practice used one regular long-term locum GP to fill the staff rota and this increased the practice's ability to provide continuity of care to patients who valued this.
- The practice had a number of non-clinical staff who acted as leads. For example, the practice had a referral team lead to help ensure that referrals were prioritised to make sure patients who need to see a specialist receive prompt assessment. The referral team lead monitors the referrals process to ensure patients who are provided with dates for follow up are reviewed in a timely manner.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. The practice continued to develop their lists of patients with chronic diseases and long-term conditions including patients with mental health disorders and signposted patients to extra support.
- The practice maintained a spreadsheet list of patients with poorly controlled diabetes and staff were able to identify patients who had not attended the surgery and follow up with these patients to book them in for their reviews and health checks.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 6.30pm Monday to Friday. Early morning appointments were available from 7.00am on Mondays and late evening appointments till 7.30pm Tuesdays. The practice had urgent appointments which can be booked on the same day. Routine appointments could be booked in advance (maximum four weeks). Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a Primary Care Network.
- 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.

### 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 <sup>1</sup>
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. The practice gave examples of how they had engaged with those patients and their families who were unable to use the phone or digital platforms to offer them care or treatment. They had a quality improvement plan which included changes they had made to address patient feedback about difficulty accessing appointments. Appointments could be booked on the same day and in advance through the online patient access App. The practice had introduced a red, amber and green triage protocol to help staff identify patients who needed to be seen face to face.</li> </ol>	

### 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)	40.4%	N/A	52.7%	No statistical variation

The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	33.1%	52.9%	56.2%	Tending towards variation (negative)
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)	31.7%	52.9%	55.2%	Variation (negative)
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)	39.8%	67.2%	71.9%	Significant variation (negative)

**Any additional evidence or comments**

In comparison to 2021 National GP Survey results, the 2022 published results showed that patient satisfaction regarding access had decreased. We checked what actions the provider had taken to address the access issues found at this inspection. The provider told us they had made a number of changes to improve the quality of access to appointments:

**Call waiting time**

The practice were aware of patient dissatisfaction with getting through by phone. We saw some evidence of actions to improve patient experience of how easy it was to get through to the practice by telephone, for example;

- The practice shared an example screenshot from the live performance dashboard to demonstrate how they were monitoring daily appointment access over the telephones.
- The practice had developed a system to audit live telephone calls statistics, in terms of incoming calls, pick up times by individual staff and call duration. Staff reviewed reports of call duration and call answering in reception team meetings.
- During busy periods the practice could review the capacity required to ensure good telephone response. The practice told us they had employed more receptionists to deal with the increased call volume.
- The practice had increased call handling during peak times. The practice has recruited a reception supervisor (in addition to the reception manager) to help improve standards of service. Reception staff had completed customer services training courses.
- Managers supported staff with customer service training and arranged in house training on how to manage difficult situations when answering calls.
- The provider told us they continue to audit Friends and Family Test (FFT) patient feedback and shared their monthly log of FFT scores. They told us FFT scores were reviewed at their Quality Improvement meetings.

	Satisfied with Service (%)	Recommend to Friends & Family (%)
Nov-22	67	67
Dec-22	33	33

<b>Jan-23</b>	67	61
<b>Feb-23</b>	100	57
<b>Mar-23</b>	80	55
<b>Apr-23</b>	0 (no feedback given)	55

### **Access to appointments**

We discussed the lower scoring areas in the NHS national patient survey with the practice. The practice had reviewed the 2022 GP Patient survey results and implemented an action plan. Staff told us about changes the practice had made in response to patient feedback about access. There was a process of monitoring the appointment system;

- The practice monitored monthly summaries of patient feedback collated through the eConsult system. When patients have completed an online consultation, they can offer some feedback after their consultation has taken place. The practice reviewed themes from patient feedback.
- There was evidence of positive engagement with the patient participation group (PPG) regarding access to appointments. For example, at this inspection the practice had undertaken a quality improvement project to improve the understanding of the appointment types that are available and the various ways that patients can access them. The main aim was to reduce the DNA rates and ensure patients cancel appointments if they cannot attend. The practice added a reply option to the text message reminders sent to patients on their mobile phones. Monthly DNA data is displayed in the waiting area so that patients could be informed of the number of missed appointments that month.
- Following feedback from PPG the practice reintroduced a monthly newsletter for patients and created a news board in the reception area of the practice.
- Since the previous inspection there had been an increase in staffing (both clinical and non-clinical members). The practice had recruited a full-time salaried GP and an advanced nurse practitioner to enable patients to access more face-to-face appointments.
- The practice referred patients for a minor illness consultation to the NHS Community Pharmacist Consultation Service CPCS (community pharmacy) once a local referral pathway has been agreed.
- The practice had taken action to audit live call monitoring. Staff told us they monitored the call system which allowed staff to collect data regarding the calls received from patients and used this to improve the response times as much as possible. The practice used a live dashboard which showed the number of calls answered versus number missed and tracked calls during busy periods including missed calls and how long patients had been held in a queue on the phone. We spoke to staff who told us they were able to run reports and a manager carried out a daily analysis of the telephone dashboard data.
- The practice told us they had made changes to their website to support patients accessing services. We saw there was information and signposting to support patient access to sources of advice and support in the community, symptom checkers, details of community pharmacies and self-help advice for minor ailments.
- Practice staff worked with the Primary Care Network (PCN) to increase access to appointments at local network practices and the extended hours hub.
- There was evidence that complaints were used as tools for learning and improving the service.

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Source	Feedback
NHS.uk website (formerly NHS Choices)	Thirteen NHS website reviews (previously NHS CHOICE) between March 2022 and March 2023; two x 5-star reviews and three x 2-star and eight x 1-stars indicate dissatisfaction with the delivery of the service. Comments were mixed with some positive comments about staff being helpful and supportive. Negative comments were about difficulty getting a face-to-face appointment and long waits for a call back from a GP.
Patient participation group	We asked the members of the practice participation group (PPG) about telephone access and appointment availability. They told us the practice offer a number of appointment types to suit different needs, for example, face to face, telephone and an online consulting tool but it was still difficult to get through on the phone.

### 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.	22
Number of complaints we examined.	22
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.	1

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Parent brought their child in for immunisation. The practice nurse administered the vaccination. Parent made a complaint about scarring.	GP assessed the child and diagnosed a small infection and treated. The complaint was discussed in practice clinical team meeting. GP lead discussed learning with the nurses. Now nurses advise patients that in rare instances a patient may get a scar.

## Well-led

## Rating: Good

At our previous inspection in November 2021, we rated Well Led as Requires improvement because some systems designed to keep people safe were not operating effectively in particular, monitoring patients' health in relation to the use of medicines and clinical review prior to prescribing.

**At this inspection we rated the practice as Good for Well Led because the provider had improved systems and processes and addressed the issues identified at our previous inspection. For example:**

- *Systems were in place to review monitoring results and follow up patients and leaders had a clear process of oversight and risk assessment prior to prescribing. The provider had a clear system to ensure oversight of safe prescribing.*
- *The governance arrangements had improved. There was evidence of improvement to control measures put in place to manage risk.*
- *Practice leaders had established proper policies and activities to ensure safety and assure themselves they were operating as intended.*
- *The practice had succeeded in making improvements to most aspects of performance, but there were other areas that had not been addressed effectively. For example, uptake of childhood immunisations.*

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	P <sup>1</sup>
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
1. At this inspection, there were areas where leaders had not identified the need to have an effective process in place, for example, a process to ensure staff had clicked completed in the task workflow system. However,	

leaders demonstrated willingness to address the concerns raised during this inspection.

At our previous inspection in November 2021, practice leaders had not assured themselves that policies and procedures were operating as intended for example the provider did not have oversight that clinicians reviewed monitoring before issuing prescriptions. The practice could not demonstrate clinicians were safely prescribing medicines which required ongoing monitoring. The practice had made improvements to their prescribing protocol at our inspection in March 2022. At this inspection we found the improvements had been sustained. For example, leaders had addressed concerns in relation to systems in place for monitoring patients prescribed high-risk medicines. Practice leaders had established policies, procedures and activities to ensure safety. At this inspection, our clinical review demonstrated that people received appropriate physical health monitoring and treatment in accordance with national guidance.

The practice had a programme of quality improvement activities in place to improve prescribing safety. There was a designated lead for each clinical and non-clinical area.

**Vision and strategy**

**The practice had a clear vision and credible strategy to provide high quality sustainable care. The practice had developed an effective system to monitor the quality of care.**

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y <sup>1</sup>
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:  1. At our previous inspection in November 2021, the provider did not have a comprehensive strategy to address the lack of systems and processes in place locally to ensure the service operated safely and as intended, for example in relation to medication review and prescribing. At this inspection, there was a clear vision and set of values to provide patients with high quality, personalised and holistic care. All staff were aware of the vision and we saw that this translated into the action of the practice.	

**Culture**

**The practice had a culture which drove high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Staff told us that all practice staff worked together as a team. Staff told us that the GPs and managers were very approachable. There were frequent staff meetings. Leaders encouraged staff to raise concerns. Staff said they felt confident that managers would address their concerns and issues raised</li> </ul>	

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

Source	Feedback
Practice staff	<p>Staff were committed to providing a high-quality service to patients. They consistently told us the quality of clinical care provided was excellent and something they were proud of. Staff we spoke to reported they had seen improvements since the last inspection, they told us:</p> <ul style="list-style-type: none"> <li>Policies and procedures were maintained in an organised way and easily accessible to them.</li> <li>There was a good structure in place in terms of meetings and sharing of learning with staff.</li> <li>The management had streamlined procedures and allocated specific tasks for clinical and non-clinical staff.</li> <li>Staff told us there were opportunities to progress and develop new skills.</li> <li>Staff felt confident to speak to any member of the management team if staff had any concerns.</li> </ul>

### Governance arrangements

**Governance arrangements had improved. There were clear responsibilities, roles and systems of accountability to support good governance and management.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y <sup>1</sup>

Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1. At our previous inspection in November 2021, we found the overall governance arrangements required improvement. Issues that could threaten the delivery of safe and effective care were not identified and managed. At our inspection in March 2022, leaders had reviewed governance arrangements to drive improvements.</p> <p>At this inspection, the provider had strengthened the governance structure in place to ensure priority areas of improvement were highlighted, risks identified, and actions planned. We found it had appropriately addressed concerns in relation to safe prescribing.</p>	

### Managing risks, issues and performance

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

**Risks associated with prescribing safety had been addressed since our last inspection.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	P <sup>1</sup>
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y <sup>2</sup>
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
<p>Explanation of any answers and additional evidence:</p> <p>1. Although the practice had processes to manage current and future performance, we found these had improved in some areas of performance but not others. For example, Childhood immunisation uptake rates were still below the World Health Organisation (WHO) targets. Uptake rates for the vaccines given were below the target of 95% in all of the 5 areas where childhood immunisations are measured. The practice had not demonstrated it had an effective strategy to improve their performance for cervical screening which was lower than local and England averages.</p> <p>2. At our previous inspection in November 2021, we found that the systems for identifying monitoring and mitigating risks associated with the prescribing of certain medicines were not effective. For example, the practice had a written protocol for repeat prescribing of medicines which needed monitoring, however, clinicians had not followed the protocol to ensure appropriate monitoring and prescribing has been carried out. The practice did not have a clear system to ensure oversight of safe prescribing, which</p>	



meant we were not assured that patients were always receiving the correct care, treatment and monitoring for their conditions.

At our inspection in March 2022, practice leaders had made improvements to further embed systems and assurance processes to ensure the practice managed all risks. For example, systems to manage patients who take medicines which require monitoring had improved. The practice had made changes to the prescribing protocol to support the monitoring and review of patients.

At this inspection, practice leaders had sustained improvements. For example, our review of clinical records demonstrated improvements to processes to monitor patients prescribed high-risk medicines had been sustained. We saw evidence that the practice consistently identified and responded to risks and assessed the impact on safety and quality. For example, the practice had embedded systems to audit prescribing in line with current clinical guidance.

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. We saw evidence that the practice used the results of clinical audits to improve performance.</li> </ul>	

### Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y

Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

### 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 <sup>1</sup>
The practice had an active Patient Participation Group.	Y <sup>2</sup>
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> <li>1. The provider had reviewed the results of the national GP patient survey and feedback received through friends and family test feedback and had an action plan to improve patient experience. The provider had a dedicated clinical lead and team that focused on support for patients and linking patients up with local services to help manage long term conditions.</li> <li>2. At our previous inspection in November 2021, the practice were in the process of recruiting new PPG members to regenerate interest and enable them to restart meetings. At this inspection, the practice had reinstated quarterly PPG meetings. The number of PPG members had increased to 25 members.</li> </ol>	

### Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> <li>• We spoke to one member of the patient participation group (PPG). They reported that the practice involved them and considered their suggestions. The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients. For example, the PPG gave feedback to the practice about the complaints process and the practice made the complaint</li> </ul>

procedure leaflet in waiting area more visible and also placed a complaint sheet available in the reception area for patients who wanted to make their complaint in writing. The practice posted the direct email address for making a complaint on practice website. The practice prepared the minutes for the meetings and circulated it to the PPG members. The practice GPs regularly attended these meetings, and the provider kept the PPG informed about the changes at the practice.

### Continuous improvement and innovation

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

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

### Examples of continuous learning and improvement

The practice had identified where improvement was needed and how this would be achieved. The provider had developed a number of lead roles for staff to drive improvements in the delivery of care and treatment. For example, there was a non-clinical safeguarding lead and also a referrals lead. The practice had an in-house Community Psychiatric Nurse (CPN), employed by the Integrated Care Board (ICB) who worked with the practice to support patients with mental health illnesses.

### Notes: CQC GP Insight

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

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

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band. The following language is used for showing variation:

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

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

Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

#### **Glossary of terms used in the data.**

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