

Care Quality Commission

Inspection Evidence Table

Kenyon Medical Centres (1-581971365)

Inspection date: 29 September 2022

Date of data download: 26 August 2022

Safe

Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: Staff spoken with were aware of local safeguarding policies, they knew who the practice safeguarding leads were and how to report any concerns. There was evidence of regular meetings where safeguarding discussions took place, we saw that vulnerable and complex care cases were discussed as part of the practices approach to managing safeguarding.	

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:	

We saw evidence to support that the practice carried out recruitment checks in accordance with regulations.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2022 (at Chace Avenue and Brandon Road branch)	Y
There was a fire procedure.	Y
Date of fire risk assessment: 1 July 2022 (at Chace Avenue and Brandon Road branch) Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: There were examples of actions taken to mitigate risks to health, safety and fire. For instance specific fittings were added to a fire exit door at the Chace Avenue practice to improve security and at Brandon Road compostable materials were removed from a cupboard (not accessed by patients) to reduce risk of fire.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 5 September 2022 (at Chace Avenue and Brandon Road branch)	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: We observed the main practice at Chace Avenue and the Brandon Road branch practice to be visibly clean during our inspection.	

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
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with understood how to prioritise patients who reported signs and symptoms of sepsis, there was evidence of completed training in Sepsis awareness also. Staff we spoke with knew how to respond in the event of a medical emergency and there were protocols in place for receptionists to refer to if they encountered an emergency.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Our review of the practice's patient record system highlighted some results that were marked as abnormal, which had not been viewed; some of these were dated as arrived on 16 September 2022. We explored this further with GPs during our site visit who offered assurances that they were aware of the results and none were in need of urgent action. The GPs explained that some of the results would also be viewed as part of training for the GP registrars, where they would be viewed and discussed alongside one of the GP trainers; we were assured that these were not urgent results. During our site visit we saw that the GPs were actively working through the test results and staff explained that the unviewed results were a rare occurrence as they were usually marked as viewed and filed in a timely manner.</p>	

Appropriate and safe use of medicines

The practice operated safe systems for the appropriate and safe use of medicines, including medicines optimization.

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group	0.79	0.86	0.82	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - 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). (01/07/2021 to 30/06/2022) (NHSBSA)	9.8%	9.4%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	4.97	5.17	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	187.4‰	122.4‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.91	0.71	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	12.7‰	8.3‰	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 structured medicines reviews for patients on repeat medicines. ¹	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Partial

Medicines management	Y/N/Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches:</p> <p>The practice's prescribing of psychotropics (per 1,000 patients between October 202 and March 2022) was at 12.7% (per 1000 patients), compared to the CCG average of 8.3% and England's average of 6.8%. Staff were aware that the prescribing for hypnotic and psychotropic medicines were high, some staff we spoke with highlighted that this was typically due to their patient population and complex care needs.</p> <p>As part of our inspection we reviewed a random sample of 11 clinical records for patients taking specific Disease Modifying Antirheumatic Drugs (DMARDs) and for patients taking specific high risk medicines. Our review highlighted some gaps in record keeping. For example, in four records, clinicians had noted that the recommended monitoring and tests had taken place prior to further prescribing a specific DMARD. However, the results of the tests had not been captured in the patient record system as best practice. We also saw that this was evident in two further cases where patients had been prescribed a high risk medicine. Shortly after our inspection visit, the practice offered further assurances to confirm that these patients were up to date with recommended monitoring, improved recording of results had since been reflected on as a team.</p> <p>During our inspection we identified two cases with no record of up to date monitoring for patients taking DMARDs and at the time of our inspection in one of these cases the practice was unable to demonstrate that they had considered or acted on a request from secondary care with regards to monitoring and prescribing considerations. In a further four cases, there was no evidence to confirm that the recommended monitoring had taken place prior to prescribing specific high risk medicines. We discussed these findings with one of the GPs during our site visit, they assured us that the documenting of test results had been discussed in practice and best practice reiterated the day prior to our visit. In addition we were assured that patients who were overdue monitoring had been allocated to a GP for further action.</p> <p>Shortly after our inspection, the practice offered assurances and further evidence to confirm that monitoring had taken place in secondary care for some of these patients and for others they were able to demonstrate efforts to engage and alternations made to prescribing in line with guidelines; this evidence was not clearly captured in the records we viewed at the time of our inspection.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, the system for managing safety alerts did not provide assurance that all relevant alerts had been acted on.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	Nine
Number of events that required action:	Zero
Explanation of any answers and additional evidence: The practices systems for reporting concerns, incidents and near misses were embedded throughout the practice. Minutes of practice meetings showed that actions and lessons learnt were applied to significant events.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Delayed routine referral	<ul style="list-style-type: none"> Investigation into the issue highlighted that a referral was not sent and it had not been tasked to the admin team On recognising this, a referral was processed and managed in a timelier manner, apology offered also Event reflected on during a staff meeting
Medicines dosage error	<ul style="list-style-type: none"> Medicines dosage adjusted in error by clinician Error identified through routine monitoring, significant event recorded no harm caused however an apology provided and dosage corrected Event reflected on during a staff meeting and guidelines reiterated

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: We saw that the practice had a system for recording and acting on safety alerts however we found that the system was not effective in some areas. For example, the practice was unable to demonstrate that specific alerts had been considered or acted on in line with recommendations. Specifically, we identified	

five cases where patients remained on combinations of specific medicines used to prevent blood clots and a medicine which is prescribed to treat gastric associated symptoms. There was no evidence demonstrating that discussions had taken place with patients with regards to alternative prescribing considerations, in line with the recommendations from the safety alert.

Effective

Rating: Good

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

Effective needs assessment, care and treatment

Patients' needs were not always assessed in line with current legislation, standards and evidence-based guidance.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y

Effective care for the practice population

Findings
<ul style="list-style-type: none"> Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. 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 various patient groups. The practice demonstrated that they had a system to identify people who misused substances.

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. Patients with poor mental health, including dementia, were referred to appropriate services. The practice was able to book patients in with a number of additional roles and care providers through their Primary Care Network (PCN). This included mental health support workers and social prescribers.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. 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.
- The practice was responsible for providing primary care to approximately 280 patients across five nursing homes within their locality area. The management of this care included a weekly review by a GP and one of the primary care network (PCN) paramedics, as well as regular ward rounds. At the time of our inspection the practice and the nursing homes attached to their locality, had started using a digital system which enabled the homes to have 24 hour access to requests for urgent care; this system was managed and overseen by the local district nursing team.

Management of people with long term conditions

Findings

- There was evidence to support that the practice actively identified patients with commonly undiagnosed conditions, for example chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- However, our clinical searches on the patient record system during our inspection highlighted occasions where records had not been managed in line with recommended practice. For example, we identified three patients where test results indicated diabetes which had not been coded as such on the patient record system. There was no record to evidence that they had been informed of a diagnosis and no evidence of further specific tests; such as for diabetic eye screening where required. Furthermore, the absence of effectively coding and capturing these patients on the clinical system posed a risk of them not being identified for recommended annual reviews. In other areas we saw evidence of active management for patients with diabetes, however we noted one instance where the practice recorded plans to follow up on a diabetic patient but there was no evidence in the record to demonstrate if any follow up took place as intended.
- Shortly after our inspection took place, we received evidence offering assurance that these patients had been reviewed and records made to reflect actions taken. The practice had reviewed all patients on their undiagnosed diabetes list and had embedded learning following our clinical searches.
- We saw evidence to confirm that patients who had been recorded and diagnosed 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.

- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. Patients with asthma were offered an asthma management plan and patients with COPD were offered rescue packs
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	144	149	96.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	146	156	93.6%	Met 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	149	156	95.5%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	149	156	95.5%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	150	168	89.3%	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

Staff we spoke with described an opportunistic approach to childhood immunisations, appointments were available for immunisations during all clinic times, as well as during some extended-access times and not just during childhood immunisation clinics. During our inspection we noted safe and effective arrangements for following up on any missed immunisation appointments. When necessary the practice would liaise with other agencies including health visitors and school nurses and consult their safeguarding procedures if required. Published and verified data from NHS England and Improvement showed that the practice met most of the World Health Organisation (WHO) targets for the uptake of childhood immunisations between April 2020/2021. Data highlighted that the practice was just under the 90% minimum target by 0.7%, for the uptake of the MMR vaccine for five year olds (April 2020/2021). To further improve uptake of their MMR vaccines the practice was exploring further ways of engaging further with specific patient groups, including transient families; this included being contacted directly by the GPs as part of their engagement strategy.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	72.2%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	68.1%	55.6%	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)	63.1%	60.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	54.7%	57.0%	55.4%	No statistical variation

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

Any additional evidence or comments
Published and verified data by the UK Health and Security Agency (UKHSA) for March 2022 showed that the practice was not meeting cervical screening targets. Staff described an opportunistic approach and explained that they were continuing to make efforts in encouraging patients to attend for screening appointments. Appointments were available outside of core working hours and on weekends through the primary care network (PCN) and the practices extended access arrangements. There were female sample takers in place and the practice operated effective failsafe systems to ensure results were received for every sample sent for testing. There was a systematic approach in place for call and recall; patients who failed to attend their cervical screening appointments were followed up and contacted through phone, text and by post. Unverified data provided during our inspection site visit showed that 70% of their patients aged 25-49 had been invited for screening and 79% of their patients aged 50-64 had been invited for screening between April and September 2022. As part of their engagement strategies the GPs had started to send texts out to patients directly, encouraging

engagement in the cervical screening programme. Practice nurses described an open approach to discussing cervical screening particularly with their young patients, by way of alleviating any worries and encouraging conversations about smear tests. We observed positive feedback provided to the practice, regarding successful outcomes following cervical cancer screening.

Monitoring care and treatment

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

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

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

We saw an example of a clinical audit focusing on renal function monitoring in patients taking a specific anticoagulant medicine to prevent blood clots. The audit primarily identified that in the 129 cases included in the audit, 33% of patients under the age of 75 were overdue renal monitoring and 48% of the patients aged over 75 were also overdue this monitoring. As a result of this audit recommendations were set which included implementing systematic reminders for specific monitoring tests, improved patient engagement for arranging blood tests. This audit was conducted in April 2022 and scheduled to be repeated.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

Staff had protected time for training. There was evidence demonstrating supervision in place for clinical staff, as well as oversight of prescribing practices. The practice was a training practice and at the time of our inspection there were nine GP registrars in position (registrars are doctors who are training to become GPs). We saw that GP registrars had access to dedicated GPs at the practice, with evidence of formal supervision and clear clinical oversight in place. We saw examples of where the practice offered support and funding to upskill and train staff in various areas. For instance, a member of the nursing team was studying to become an advanced clinical practitioner, they were supported and funded by the practice to partake in regular study days as part of this development.

Coordinating care and treatment

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

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

Consent to care and treatment

The practice 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
Explanation of any answers and additional evidence	
There was evidence to support that conversations about DNACPR took place as part of a broader anticipatory care planning, with use of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms in place.	

Well-led

Rating: Requires Improvement

The practice is rated as requires improvement for providing a well-led service because we identified some areas during our inspection that lacked effective clinical oversight; this was reflected across systems for acting on safety alerts, capturing diabetic patients on the patient record system and for record keeping with regards to monitoring patients on specific medicines. These were also areas that required strengthening in order to reflect good governance.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership in place however some areas lacked effective oversight.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
We noted clear lines of accountability in place during our inspection however we identified some areas which lacked effective oversight; this was reflected across systems for acting on safety alerts, as well as effectively capturing diabetic patients on the patient record system and for record keeping specific to the monitoring of patients on certain medicines. Some of these areas were acted on shortly after our inspection, however the practice could not demonstrate that these areas were actively being addressed prior to our inspection.	
Staff were actively supported and encouraged to acquire new skills, we noted examples where clinical staff were supported to partake in professional development courses and non-clinical staff who were being supported to undertake training in areas such as phlebotomy.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was evidence of a formal business plan in place for the practice as well as evidence of a demonstrated commitment to system-wide collaboration and leadership. Some of the leadership team at the practice were members of their Primary Care Network (PCN) and there was active practice engagement across the network and with other practices in the locality area. The practice had adjusted to working under increased demand by altering and extending the premises at Chace Avenue and the Brandon Road branch, over the years. These changes included the conversion of a consultation room from one to two rooms at Chace Avenue, and the development of a remote access working Hub at Brandon Road for clinicians to use for their remote consultation work.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior 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> <p>Staff spoke positively about being encouraged, and encouraging one another, to speak up and raise concerns as well as suggestions at work. Staff described the practice as a safe space to share any concerns or issues, at all levels. We saw that practice policies, complaints and significant event records positively supported this process and reflected compliance with the requirements of the duty of candour.</p>	

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

Source	Feedback
Feedback from staff and conversations with	Staff we spoke with said they enjoyed coming to work. Staff described an open culture, that patients came first and that the practice had a 'family feel'. They spoke positively about various staffing teams and noted their confidence in the

staff we spoke with during our inspection.	management team, describing leaders at the practice as approachable and friendly. Those requiring clinical supervision described an open-door policy, advising that the GPs were always on hand to help if needed. Conversations with clinicians highlighted a passion for patient centered care.
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Governance arrangements

There were clear responsibilities, roles and systems of accountability in place but in areas they did not reflect good governance.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: During our inspection we identified some areas that required strengthening in order to reflect good governance. For example, this was evident across systems for clearly recording blood test results in patients taking certain medicines, as well as with regards to effectively capturing diabetic patients on the patient record system. Although these areas were acted on shortly after our inspection, the practice could not demonstrate that they were addressed prior to our inspection.	

Managing risks, issues and performance

Some of the practices processes for managing risks, issues and performance contained gaps.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: We noted some gaps in effective governance and oversight of clinical systems specific to managing a safety alert and with regards to capturing all diabetic patients on the system; these highlighted potential risks and there was no evidence to demonstrate that the practice had identified or made efforts to manage this prior to our inspection.	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y

Appropriate and accurate information

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

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

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

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.	Partial
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:	
<p>We saw that changes were implemented following engagement with staff and feedback from patients. Examples included, introducing headsets for improved telephone privacy at the reception desk, the installation of check-in screens and the suggestion of developing a Hub for remote consultations. Due to the impact of the Covid-19 Pandemic the practices Patient Participation Group (PPG) was no longer active, therefore they were in the process of reestablishing their PPG. We saw that a survey had been conducted initially to gauge interest and a meeting was planned in October 2022 to progress with working on reinstating the group.</p>	

Feedback from Patient Participation Group.

Feedback
At the time of our inspection the practice was in the process of reestablishing their PPG.

Any additional evidence
<p>During our inspection we observed a sample of feedback provided by patients through the practice's website. Across the four responses we viewed, feedback was positive with regards to care and treatment provided. Clinical staff were described as caring and receptionists were described as kind, helpful and welcoming. The practices results from the National GP Patient survey were consistently positive with regards to access, this included telephone access and was also reflected across the peak periods of the Covid-19 pandemic. For instance, results from the published and verified survey in 2021 showed that 90% of the respondents said it was easy to get through to the practice by phone (January 2021/March 2021) compared to the national average of 68%. Results from the most recent survey (January 2022/April 2022) showed that in addition to high satisfaction regarding phone access, patients were also satisfied with their appointment times. Staff we spoke with expressed that the practices rota system helped to ensure that the phonelines were always covered. Specifically the practice rota was developed to ensure that there was always a member of staff on shift, working between the morning and the afternoon staff; this overlap enabled the practice to always have phone cover.</p>

Continuous improvement and innovation

There was some 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: There was evidence of an open culture in place, as well as some evidence to support that learning was used to drive improvements. This was demonstrated across changes to systems and process following significant events, complaints and feedback from staff and patients, and through investing in upskilling and training staff. The practice was able to refer patients to a number of additional roles which were available in-house. This included access to on-site paramedics, first contact physiotherapists, podiatrists, dieticians, mental health support workers, a healthy lifestyle coach and a social prescriber. These roles were facilitated and managed through the practices primary care network (PCN).	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -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.