

Inspection Evidence Table

Elm Hayes Surgery

(1-552830252)

Inspection Date: 26 May 2023

Date of data download: 24/05/2023

Overall rating: Requires Improvement

At this inspection in May 2023, we rated the practice as Requires Improvement because:

- The provider was unable to demonstrate that appropriate monitoring of patients prescribed high-risk medicines was being carried out consistently when prescribing.
- Patients did not always receive effective care and treatment that met their needs. In particular, monitoring of patients with long-term conditions in line with national guidance.
- There was evidence that the process for managing safety alerts was not being followed appropriately to ensure patients were protected from harm.
- There were gaps in mandatory training for clinical and non-clinical staff. There was a lack of oversight to monitor staff training compliance.
- The service was not ensuring that persons employed by the provider were receiving appropriate support to prevent lone-working.

Safe

Rating: Requires Improvement

At this inspection in May 2023, we rated the practice as Requires Improvement for providing safe services. This was because:

- The provider was unable to demonstrate that appropriate monitoring of patients prescribed high-risk medicines was being carried out consistently when prescribing.
- There was evidence that the process for managing safety alerts was not being followed appropriately to ensure patients were protected from harm.

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.	Partial
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> <ul style="list-style-type: none"> • There was a safeguarding system and policy in place for children which was reviewed in May 2023. The practice sought guidance from the Bath and North East Somerset (BaNES) locality Safeguarding lead for processes relating to safeguarding vulnerable adults. There were designated safeguarding leads at the practice and policies had arrangement and key contacts for making a safeguarding referral. • Not all staff had received the appropriate safeguarding training. There was a lack of oversight to ensure staff training compliance so that staff had the knowledge and skills to protect patients from potential harm. For example, we found 2 GPs who had not completed safeguarding children and vulnerable adults level 3 training and 3 non-clinical staff who had not completed safeguarding children and vulnerable adults level 1 training. • Senior managers and lead GPs discussed safeguarding at regular monthly meetings. Local community multi-disciplinary (MDT) safeguarding meetings took place which involved the community matron, health visitors and social workers. Relevant information was recorded in patient records we sampled. • Children who did not attend planned appointments with their parent or guardian were managed by the local hospital who communicated with the practice routinely. This was appropriately coded on the patient records system to ensure relevant safeguarding information was in place. • A mixture of clinical and non-clinical staff members had chaperone responsibilities as part of their role. Those staff members had completed the relevant training and Disclosure and Barring Service (DBS) checks for clinical staff and risk assessments had been completed for non-clinical staff. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a recruitment policy in place which had been reviewed in August 2022. This included how the practice processed personal data in accordance with the General Data Protection Regulations (GDPR). • The practice had an induction programme for clinical and non-clinical staff which included information for training and appraisal, health and safety and fire procedures. • We carried out recruitment checks in relation to 3 members of staff which contained all of the required information as per practice policy, including Disclosure and Barring Service (DBS) checks. • The practice held information about clinical staff role specific immunisation history in line with national guidance. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: January 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: January 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> There was a health and safety risk assessment that included observations, recommendations and mitigating actions to visitor security, emergency procedures, lone working, hazardous substances and building access. The practice had completed fire alarm servicing and fire extinguisher servicing annually, records were maintained to document this. Staff had completed training relating to fire safety and there were dedicated fire wardens for the practice. The fire risk assessment conducted deemed the premises compliant. There was a fire evacuation chair available due to the premises being on two floors. The practice manager was trained to carry out this procedure in an emergency and there were plans in place to extend this training to all fire wardens. Fire drill records were recorded and completed annually; we saw evidence that this had last been conducted in August 2022. Equipment calibration testing had been completed in December 2022. At the time of inspection, the practice had not yet completed but had booked an annual portable appliance testing assessment prior to the site visit. After the inspection, we saw evidence that this had been completed and equipment was compliant. Legionnaire servicing had taken place in February 2023. Legionnaire's disease is a potentially fatal type of pneumonia, contracted by inhaling airborne water droplets containing viable Legionella bacteria. All hot and cold water systems in the premises are a potential source for legionella bacteria growth. Records of monthly water checks and flushing records were completed by staff. The provider was aware of their duty and responsibility to notify the UK Health Security Agency (UKHSA) of cases under the service provision. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met. Training was not always kept up to date.

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

Explanation of any answers and additional evidence:

- The infection prevention and control (IPC) policy was reviewed in September 2022. Standard operating procedures were in place and had been reviewed by the provider IPC lead. The IPC lead was able to demonstrate a comprehensive understanding of infection, prevention and control and their role in ensuring the practice complied with national guidelines.
- Staff were not always up to date with IPC training. We saw evidence of two members of clinical staff with mandatory modules that had either expired and were due for renewal or had never been completed according to the practice's own training policy. The provider had a plan in place to improve systems to monitor staff training compliance, but this has not yet been demonstrated.
- The practice had completed an IPC audit in January 2023. Appropriate measures were in place to ensure the premises was clean and that guidance was available for procedures relating to non-touch technique, hand washing, clinical waste, needlestick injuries and personal protective equipment (PPE). Sufficient information needed to plan safe care was available to staff and patients.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety but these were not always embedded.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
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> <ul style="list-style-type: none"> • The practice had a team of 8 GPs, of which, there were 4 partners and 4 salaried GPs. The practice had a team of 2 advanced nurse practitioners and 3 practice nurses who provided appointments under the triage model and held nurse led clinics for long-term conditions. The practice had a dispensary which had a team of a pharmacy technician, 2 dispensers led by a dispensary lead. • There was a recruitment policy for new members of staff with training and guidance for locum and temporary staff. The practice was supported by several additional roles reimbursement scheme (ARRS) staff and shared staff resourcing across the Primary Care Network (PCN), such as care co-ordinators and social prescribers. • Staff rotas were completed with oversight of cover where required, so that should a clinician be absent at short notice, their pre-booked appointments could be put into protected available same day slots with another clinician. There were ineffective staffing arrangements to ensure in the event of emergency, the risk of unsafe practice was mitigated. We saw examples of lone working from January 2023 in the dispensary. There was a risk that staff were unable to safely complete tasks relating to medicines where there was also a requirement to serve patients. Systems and processes failed to raise this issue in the first instance. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a dedicated administration team of staff who were responsible for summarising records. We found the practice was up to date with summarising patient records. The administration team were responsible for ensuring urgent and routine patient referrals were actioned and followed up. For urgent referrals, there was a system for staff to check patients had attended their appointment. The practice had a 'buddy' system to cover clinician absences for outstanding patient results to ensure these were followed up appropriately. 	

Appropriate and safe use of medicines

The practice did not always effectively use their systems for the appropriate and safe use of medicines, including medicines optimisation.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	0.81	0.79	0.86	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	5.9%	9.3%	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	4.77	4.82	5.24	No statistical variation

Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	110.6‰	123.6‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.67	0.60	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	4.7‰	5.9‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	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.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y

There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	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:</p> <ul style="list-style-type: none"> • Clinical supervision was given by the practice's lead GP, providing oversight of performance and to check non-medical practitioner prescribing was within scope of practice to ensure safe care and treatment. Audits and conversations were recorded for both of these members of staff at the practice. • During this inspection we undertook remote searches of the practice's clinical patient records system to determine whether patients who had been prescribed high-risk medicines had been appropriately monitored and reviewed. We found that: • We identified 1,030 patients who were prescribed Angiotensin-converting enzyme (ACE) inhibitors or Angiotensin II receptor blockers (A2RB), medicines used to treat high blood pressure. Of those patients, 43 had not received the appropriate urea and electrolytes (U+E) blood monitoring for the previous 18 months. There was not sufficient oversight and monitoring of medicines to ensure safe care and treatment was given to patients. The monitoring of patients on high-risk medicines was not always in line with National Institute for Health and Care Excellence (NICE) recommendations, for patients 1-2 weeks after starting these medicines or when there was an increased dose. As well as monitoring patient blood pressure results at least annually. • We identified 26 patients who were prescribed Potassium sparing diuretics, medicines used to treat high blood pressure or congestive heart failure. Of those patients, 10 had not received the appropriate renal function and electrolyte monitoring. The recommended blood monitoring is 1 week after initiation or increase in dose, monthly for the first 3 months, then quarterly for a year, and then every 6 months. Patients prescribed this medicine required regular blood monitoring to ensure they are being prescribed the appropriate dose and to ensure hyperkalaemia does not occur (when potassium levels are too high, increasing the risk of damage to the heart). There was not sufficient oversight and monitoring of medicines to ensure safe care and treatment was given to patients. The monitoring of patients on high-risk medicines was not always in line with National Institute for Health and Care Excellence (NICE) recommendations. • We identified 287 patients who were prescribed Direct-Acting Oral Anticoagulants (DOAC), medicines which can prevent stroke by preventing blood clots, of which 26 patients had not received the appropriate blood monitoring (full blood count and liver function test) in the previous 12 months. Patients prescribed blood thinning medicines should have regular checks of their kidney function and calculation of their creatine clearance level (CrCl) to ensure they are being prescribed the appropriate dose, and whether it was appropriate for the patient to remain on the treatment. There was a lack of safety netting to identify outstanding monitoring and a risk that patients did not receive the appropriate safe care and treatment. • We identified 60 patients who were prescribed Methotrexate, a medicine used to treat inflammatory conditions. We found 19 patients who had not received the appropriate full blood count, renal and liver function blood monitoring for the previous 3 months. We reviewed 6 patient records and found all 6 patients had not had the appropriate monitoring in relation to the prescriber checking monitoring was up to date prior to issuing further prescription to ensure patient safety. Records did not show the day of administration of the medicine nor link it to the underlying problem. National guidance states to record the day of administration to prevent overdose due to the nature of the high-risk medicine. • The practice had a process to manage information changes to a patient's medicines including changes made by other services, for example, the out of hours provider (OOH). These were not always followed effectively when patients had pathology results from secondary care, such as the local hospital. We saw examples of patients who were prescribed the high-risk medicine, Methotrexate, where pathology results 	

had been received from the hospital database that had not been downloaded and recorded onto the patient medical records. This showed as patients were overdue blood monitoring upon reporting and the practice had not routinely recorded that these indicated it was safe to continue prescribing the medicines.

- Emergency medicines were stored on a crash trolley, accessible to appropriate staff. There was a stock of medicines within a locked cupboard, with evidence of regular stock checks including a review of expiry dates. Medicines had been risk assessed to ensure appropriate medicines were included. Medical equipment included a defibrillator as well as an oxygen cylinder, with a service agreement for the replacement when oxygen levels were low or expired.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
Explanation of any answers and other comments on dispensary services: <ul style="list-style-type: none"> • The dispensary service had effective leadership from the GP Partners and medicine management lead. The dispensary lead supported staff in their designated roles. Staff competencies were reviewed and appraisals conducted annually. • There was a comprehensive standard operating procedures, which covered all aspects of the dispensing process and there was a system in place to monitor staff compliance. Dispenser audits were carried out for quality assurance. • There was a process for Controlled Drugs (CD) disposal. We saw evidence of an audited CD log. Controlled Drugs were stored in a locked cupboard, the keys were kept securely in a designated place. There was a set procedure for the dispensary issue of Controlled Drugs to patients. 	

- We saw evidence of a significant events overview, specific to the dispensary, which discussed the actions taken and shared learning. Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts specific to the dispensary included authorised verification reviews completed by the dispensary lead.
- The dispensary took part in the Dispensing Services Quality Scheme (DSQS) annual audit which focused on dosage instructions for CD prescriptions. The dispensary showed evidence of regular patient searches for those prescribed class 4 and 5 CDs to check the quality of prescription dosage instructions. The dispensary reported to the relevant GP to change dosage instructions and update records if required. There was an action plan in place to complete a re-audit, training for staff and a set agenda item to the dispensing team meetings.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong but safety alerts were not monitored effectively.

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: 9	Y
Number of events that required action: 4	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff were clear on their roles to raise safety incidents and how to report concerns appropriately. • The practice was able to evidence learning and the dissemination of information relating to significant events. Following a significant event, the practice advised learning from the event was investigated and discussed at quarterly team meetings, where formal minutes were recorded and evidenced. 	

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

Event	Specific action taken
An incident occurred where a patient wanted to book an appointment but had incorrect contact details on record for the practice to follow-up and therefore was unable to receive the care and treatment requested.	The process for new patient registration forms was reviewed by the practice management team. Further checks were in place for patients to record full contact details, including next of kin, carers details and parental / guardian details to minimise the risk of reoccurrence. Learning had been shared with staff through a significant event meeting.
An incident occurred where a repeat prescription for a patients' medicines was issued too frequently. The practice had only become aware during an annual patient review.	The incident was investigated upon learning about the prescribing error on annual patient review. The patient was informed and the duty of candour was applied. The provider updated their clinical system to ensure safety

	mechanisms were in place to prevent excessive prescribing in line with medicine management policy and to minimise the risk of reoccurrence. Learning had been shared with staff through a significant event meeting.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The provider was unable to demonstrate that there was an effective system to ensure safety alerts were acted upon in a safe way to patients. During our clinical searches, we found 4 patients aged 65 or older who were prescribed citalopram greater than 20mg or escitalopram greater than 10mg, medicines used to treat depression. This was despite a 2014 safety alert warning of the risk of arrhythmia (an irregular heart rhythm) and risk of prolongation QT interval (heart related issues), along with the contraindication to prescribe with other medicines that prolong QT interval. We reviewed all 4 patients and found that none were informed of the risks associated with the safety alert and continued to be prescribed in combination. This was despite medicine reviews taking place and clinicians not responding to system alerts. If patients decline to reduce the medicines dose, there should be a risk assessment on record by completing an echocardiogram (ECG) and a record of discussion with the patient that they are prepared to take the risk of continued prescribing and are aware of other contraindicated medicines. We saw no evidence of this on the patient records and therefore were at risk of unsafe care and treatment. We identified 6 patients identified who were prescribed the combination of clopidogrel, a medicine used to prevent blood clots and omeprazole or esomeprazole, medicines used to treat acid reflux or protect against stomach ulcers. Not all patients were informed of the risks associated within the safety alerts and had continued to have been prescribed in combination. This was despite a 2014 safety alert warning of the risk reduction in efficacy of clopidogrel when prescribed in this combination. 	

Effective

Rating: Requires Improvement

We have rated the practice as Requires Improvement for providing effective services because:

- Patients did not always receive effective care and treatment that met their needs. In particular, monitoring of patients with long-term conditions in line with national guidance.
- There were gaps in mandatory training for clinical and non-clinical staff. There was a lack of oversight to monitor staff training compliance.

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

Effective needs assessment, care and treatment

Patients' needs were assessed, but care and treatment was not always 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.	Partial
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • GPs referred patients to secondary care and used two-week pathways where appropriate. • Patients were given advice on what to do if their condition deteriorated, for example, call backs or contact with the out of hours service. Communications between the out of hours service was effective and proactive, senior clinical staff told us this included the transfer of discharge notifications and changes to patient's prescribed medicine. 	

- Clinicians employed by the practice had regular appraisals conducted both internally and externally by the local deanery. Evidence was demonstrated to show that clinicians were kept up to date with current guidelines and evidence-based practice.
- The practice did not always use recognised clinical templates effectively which would have ensured best practice guidelines were always followed. Our remote clinical searches showed the monitoring of clinical care was not always clearly recorded. For example, 3 patients were identified as having a potentially missed diagnosis of diabetes. We reviewed all 3 patients and found there were shortfalls in coding these correctly, a systematic approach to identify patients who require monitoring upon a clinical search. The provider had not followed the correct interval monitoring guidance to establish a diagnosis of diabetes and patients had not been informed of the diagnosis.

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.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed 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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long-term conditions

Findings

- We found, patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met. We identified issues with patient medicine reviews and the process for outstanding monitoring of long-term conditions.
- The remote searches that we undertook of the practice's clinical patient records system showed that there was a lack of oversight of some long-term condition management to ensure safe care and treatment was given to patients. The monitoring of patients with some long-term conditions were not always followed in line with National Institute for Health and Care Excellence (NICE) recommendations.
- We identified 315 patients with hypothyroidism, a condition which results in low activity of the thyroid gland. Of those, 25 patients had not received the appropriate thyroid function (TFT/TSH) blood monitoring within the last 18 months.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. Patients with asthma were offered an asthma management plan.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example 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.

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)	107	108	99.1%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	119	119	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	119	119	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	119	119	100.0%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	141	144	97.9%	Met 95% WHO based target

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

- Clinical staff we spoke with were aware of the practice's initiative to provide further education to assist young families in the importance of these immunisations.
- The practice monitored Did Not Attend (DNA) appointments with appropriate follow-up processes to ensure children were safeguarded from potential abuse or neglect.

- Staff had the appropriate skills and training to carry out reviews for this population group. Staff had access to annual immunisation updates and followed the NHS green book, which sets out immunisation schedules, patient information and contraindications.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	76.8%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	76.9%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (31/12/2022 to 31/12/2022) (UKHSA)	78.4%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	63.3%	59.5%	54.9%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> The practice did not meet the minimum 80% target of eligible patient uptake of cervical screening. The provider combined health appointments with other acute or routine patient needs where possible. At the time of inspection, cervical cancer screening appointments were available to book in advance. The provider took action by inviting eligible patients when reporting had shown the practice was below England target comparison in December 2022. There were further plans in place to improve the administration processes to recall patients for cervical cancer screening. The practice had a proactive system to manage two-week wait referrals, these areas were prioritised. A two-week wait referral ensures patients who present symptoms that may indicate an underlying cancer are referred to secondary care to be seen as quickly as possible.

Monitoring care and treatment

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

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

The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> An audit was conducted to help identify and reduce initiation of the prescribing of high dose opioids with reduced duration in non-cancer related pain management. All patients that were prescribed 120mg or more of oral morphine (medicine used to treat severe pain) daily that were not being treated for cancer would require bi-annual reviews. The aim was to achieve medication optimisation and appropriate dose reduction through optimising non-pharmacological options. Patients were encouraged to engage with practice care co-ordinators, social prescribers as well as other members of the multidisciplinary team. Bi-monthly reports were completed by the pharmacy team to measure effectiveness. After 12 months, relevant patients were sent a survey, filling out a rating of the service and highlighted areas that may of helped with chronic pain management. <p>Cycle one results showed 122 patients were identified as having a polypharmacy of dependence forming medicine and received a structured medicine review. Of which 2 patients who were prescribed 120mg of oral morphine received a structured medicine review and reduced their dosage with other treatment options accessed.</p> <p>During medicine reviews for these patients, it was noted that patients were aware of the importance of engagement with the multidisciplinary team and to appropriately reduce medicine dosage. The provider implemented a new process for patients prescribed these medicines would receive a bi-annual recall for further medicine review and further advice for patients prescribed these medicines was offered.</p> <p>Second cycle audit results were due to be reviewed and compared in July 2023.</p> <ul style="list-style-type: none"> The dispensary team had completed a prescribing safety audit of medicines, with schedules set across 2022 and 2023. This detailed actions as tasks set to review patient monitoring including blood monitoring and structured medicine reviews. The dispensary team conducted a further audit to assess patients who were prescribed Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) with the risk of hospital admission due to acute kidney injury (AKI). NSAIDs are medicines that are used to relieve pain and reduce inflammation. Acute kidney injury is a condition where the kidneys suddenly stop working properly. National guidelines states that guidance should be given to patients when they are well, about how to manage their own medicines should they become unwell (vomiting, diarrhoea, fevers and excessive sweating), a process called 'sick day' guidance. The reason why guidance is given to patients is that NSAIDs impair renal function and may increase the risk of AKI. <p>The practice had assessed 40 patients and asked 6 key questions. 37 patients were not aware of the 'sick day rule'. 35 patients were not aware to stop the medicines if feeling unwell. 34 patients were not confident on when to restart medicines after an illness.</p> <p>The practice was able to determine that 23 patients would benefit from a reminder card to help abide by the 'sick day' rule and therefore plans were in place to adopt this new process for patients on this medicine.</p>	

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles, but training was not always monitored effectively.

	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.	Partial
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: <ul style="list-style-type: none">• There was a system for staff to complete training online. However, there was evidence that mandatory training had not been completed by all staff members that were essential to their roles. For example, incomplete modules such as safeguarding children and vulnerable adults as well as infection prevention and control (IPC), fire safety and information governance. There was a lack of oversight to ensure mandatory training for staff was kept up to date and therefore a risk that staff were unable to provide safe and effective treatment.• We observed records which verified appraisals were conducted with staff, performance monitored and objectives set. Staff were supported to meet the requirements of professional revalidation, including registrations with the General Medical Council (GMC) and Nurse Midwifery Council (NMC), where appropriate.• There was a recruitment policy which outlined the process for new starters. Induction checklists were in place for new staff members for probationary review. Induction guidance was available for locum and temporary staff.	

Coordinating care and treatment

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

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

Explanation of any answers and additional evidence:

- The practice had a system to manage communication between services about patients so that they received consistent and co-ordinated care. For example, meetings took place between the local Out of Hours service and the provider for the safe handover of clinical records and treatment plans of patients moving between the services. The practice used a task management system which clinicians to raise specific clinical tasks with the lead GP outside of the set daily meeting as a safety mechanism.

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: <ul style="list-style-type: none"> The practice had access to PCN care co-ordinators and social prescribers who signposted patients to community sources of support. 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 three care homes in the surrounding area of which had allocated clinicians employed to provide care for residents. Daily home visit appointments were available to those patients that were vulnerable and considered high-risk. 	

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
Explanation of any answers and additional evidence:	

- During a review of clinical records, we identified that consent and decision making was recorded in line with legislation and guidance.
- We reviewed five patients with a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) record to consider whether the DNACPR had been prepared and agreed appropriately. The records were signed and authorised with the latest reviews within the required 12-month date. Recommended Summary Plan for Emergency Care and Treatment (RESPECT) forms were used for end of life patients where appropriate.

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had completed a patient needs analysis and identified that patients with urgent issues were less able to contact the practice via telephone during the first hour of opening (08:00am-09:00am). The practice had implemented an appointment system where only patients with urgent and emergency issues would be able to book appointments over the telephone between 08:00am – 09:30am. Patients with routine queries and problems were asked to contact the practice for appointments after 09:30am. The practice had implemented a new telephone-based system that had capacity to monitor call waiting times, people in the telephone queue and call abandonments. This also gave patients information on services available; redirection to speak with the most appropriate member of staff to deal with their query and where they were in the queue. There was a plan in place to monitor telephone data through weekly reports to identify trends and to manage administration staffing capacity in line with demand. Reasonable adjustments were in place for patients such as extended appointments. The premises had a portable hearing loop in place for patients with hard of hearing. Accessible communication formats such as large print materials and information in braille was available when required. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00am – 6:30pm
Tuesday	08:00am – 6:30pm
Wednesday	08:00am – 6:30pm
Thursday	08:00am – 6:30pm
Friday	08:00am – 6:30pm

<p>Appointments available:</p>	<p>Routine appointments with a GP were available to be booked on the day from 09:30am and up to 6 weeks ahead of time.</p> <p>Urgent same day appointments were available and triaged by a duty GP and advanced nurse practitioners.</p> <p>Appointments were held from 08:30am – 11:00am and 2:00pm – 6:00pm.</p> <p>Telephone consultations (suitable for ongoing problems and issues not requiring physical examination) were available by remote locum GPs.</p> <p>Home visit appointments were available between 08:30am – 4:00pm.</p> <p>The practice worked in partnership with other local practices in the Primary Care Network (PCN) to provide additional access to appointments on weekday evenings up to 9:00pm and Saturday mornings 08:00am – 12:00pm.</p>
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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. This service was in conjunction with practices in the primary care network (PCN) and was operated by a lead GP and a visiting paramedic.
- Early morning phlebotomy appointments were available from 08:00am.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. For example, health initiative programmes such as Age concern; Bath Mind and National Diabetes Prevention.
- Community education sessions were held at the practice for patients such as menopause support; community mindfulness and smoking cessation.
- Additional nurse appointments were available outside of normal opening hours for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances and carers.
- Carers were offered referral to the Adult Carers Service who provide relevant information and advice and contacts to local support services.
- 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
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the time of inspection, the practice provided evidence to show that routine GP face to face appointments were available 4 weeks ahead of time, including nurse led clinics such as immunisations and female health clinics. This information was clearly presented for patients on the practice website or within the practice waiting area. Urgent and routine appointments were available for patients on the same day. The practice had used a triage system to allocate appointments according to clinical need. Online access to appointments was available. Patients seen through Out of Hours services had their records sent to the practice through task management processes. The practice reserved dedicated appointment slots for patients from the Out of Hours service to book into. Weekly ward rounds were completed for patients residing in nursing and care homes attached to the practice. 	

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)	61.1%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall	72.6%	63.6%	56.2%	No statistical variation

experience of making an appointment (01/01/2022 to 30/04/2022)				
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)	54.1%	61.0%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	75.2%	77.1%	71.9%	No statistical variation

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.	38
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a complaints policy in place which included a complaints response timeframe of 10 working days for investigation. Further acknowledgment communication was sent to patients that exceeded this timeframe. The practice manager implemented a 'you said, we did' as a proactive approach to presenting actions taken by the practice in the form of a complaints log. We reviewed three complaints, of which all were provided with satisfactory responses, were resolved and learning shared with staff where necessary. Informal complaints were generally resolved on the same day, if the informal complaint was not resolved on the day, this was re-categorised as a formal complaint and would follow the formal complaints process. The practice had an open and transparent approach to complaints. Investigations were conducted by relevant practice management staff in conjunction with senior GP partners for clinical input. Outcomes from investigations were shared at team meetings and with individual staff as needed. Information on how to complain was available on the practice website and via leaflets displayed in the practice. This included information on how to escalate a complaint to the Public Health Service Ombudsman (PHSO) and NHS England (NHSE) if required. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
There were delays in telephone access to make appointments and speaking with a member of staff.	At the end of 2022, the practice had implemented a new telephone system which made improvements. These included; notifying patients of where they were in the queue, options to divert to speak with specific members of staff to assist with different queries and signposting to relevant services where required. The practice had made changes to their appointment model so that the release of appointments was staggered throughout the morning for urgent and routine appointments. Reception staff had received further communications training.
Patient had not received prescription at the pharmacy	The practice investigated the reason as to why the patient had not received the prescription and responded in line with the complaints policy. The patient had temporarily changed the nominated pharmacy. The practice had updated administrative processes to ensure checks were in place to confirm patient nominated pharmacies.

Well-led

Rating: Requires Improvement

We have rated the practice as Requires Improvement for providing Well-led services because:

- Governance processes were in place but oversight of systems to monitor the quality of care in relation to the management of patients who were prescribed high-risk medicines, patients with long-term conditions and patients affected by safety alerts was not always effective.
- The service was not ensuring that persons employed by the provider were receiving appropriate support to prevent lone-working.
- The service did not always monitor and manage staff and patient feedback to drive service improvement.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had a lead GP who was supported by partners across Three Valleys PCN. The practice manager was in the process of becoming a project lead for the PCN and handing over key management responsibilities to the 2 operations managers in place.• The practice had a succession plan in place to replace those who were likely to retire and planned to support staff to encourage leadership in key areas in the practice.• We saw evidence of a quality improvement plan in place that targets and timescales that were reviewed during leadership meetings. For example, the practice was working towards improving the human resource (HR) system through an external platform to encompass all policies and procedures including staff training and appraisal information for better oversight to governance processes.	

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	

- There was a mission statement displayed on the practice's website which staff told us they knew about. Staff told us they were proud to work for the practice, albeit there were challenges placed with workload due to reduced staffing numbers.
- The GP partners and the practice management had a vision for the practice to have a strong leadership which promoted improvement for staff and patients.
- The provider had a set of values developed with staff to support the overall mission statement.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	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.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The incident reporting system complied with the requirements of the duty of candour. • The practice had an employee assistance program (EAP) in place for advice on issues that might be affecting wellbeing and performance. However, staff told us they felt that the practice could do more to improve staff wellbeing. For example, there was no mental health first aider at the practice to support staff with mental health concerns and staff feedback was not obtained formally. Practice management said they had an 'open door' policy for staff to share their views and feedback. The practice did not have access to a freedom to speak up guardian for independent impartial advice or to raise concerns. The practice had a whistleblowing procedure available for staff to access. • There was lack of oversight in the system to manage mandatory training compliance. Equality and diversity training had been completed by some staff. 	

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

Source	Feedback
23 staff CQC feedback forms	Common themes included: <ul style="list-style-type: none"> • Staff felt communicated to in relation to service updates and changes made to policies and procedures. Staff received meeting minutes, newsletters and outcomes relating to incidents and significant events was available on the staff intranet. • Patients had plenty of options to access care by the practice and this was supported by staff across the organisation.

	<ul style="list-style-type: none"> Staff felt that leaders were approachable despite that the practice could do more to improve staff wellbeing.
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Governance arrangements

There were clear responsibilities, roles and systems of accountability to support management decisions. However, governance arrangements were not fully embedded.

	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
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> <ul style="list-style-type: none"> Governance structures were not always in place to provide well-led services which were regularly reviewed. We found there were shortfalls in oversight of some areas. For example, the practice protocol for the reviews of patients with long-term conditions, patients prescribed high-risk medicines and patients affected by safety alerts were not always effective to ensure safe care and treatment. There was a lack of an effective structure to discuss performance of these clinical areas as a leadership team to ensure these processes were undertaken in line with national guidance. The practice had an action plan to review medicine management procedures and criteria for patient medicine reviews subsequent to inspection findings. Oversight of clinical governance was led by one of the GP partners, to ensure processes were reviewed and managed appropriately. The practice had a clinical team led by 4 GP partners. There was a lack of governance arrangements to ensure the registered manager was supported in delivering strategies to ensure safe care and treatment was provided. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
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:

- There was ineffective oversight of staffing arrangements to ensure in the event of emergency, the risk of unsafe practice was mitigated. We saw examples of lone working from January 2023 in the dispensary. There was a risk that staff were unable to safely complete tasks relating to medicines where there was also a requirement to serve patients. Systems and processes failed to raise this issue to prevent the risk from occurring.
- Staff feedback was not obtained formally and routinely to review issues and risks as well as any service improvement suggestions.
- A business continuity plan was in place which gave guidance to staff for the preparation of major incidents. Impact of care was assessed and involved external stakeholders, for example, other practice's within the primary care network (PCN) and the local care homes attached to the practice.
- The practice had a system in place to liaise with specialists when looking at patient management for specific conditions such as secondary care consultants at the local hospital.
- There were opportunities for staff to undertake continuous professional development (CPD).

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had not needed to make any statutory notifications to relevant organisations such as the Care Quality Commission (CQC) or National Health Service England (NHSE) within the last 12 months. However, members of the leadership team were aware of their responsibilities to do so if a notification was required. 	

Governance and oversight of remote services

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

The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The provider had a registered data controller and data protection officer. Patient data and information was stored securely in line with digital security standards with relevant information was made available for patients to access in line with privacy, consent notices and general data protection regulations. Information was available for patients on how their data was used, choices regarding consent and how to protect their online data through notices within the practice, practice registration forms or online via the practice website. 	

Engagement with patients, the public, staff and external partners

The practice did not always involve 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.	Partial
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Leaders had developed community healthcare stakeholder working arrangements in the premises, with consultation and treatment rooms in the 'Clandown Suite'. External providers were already working from the facilities at the time of inspection. The practice had not actively managed, promoted and responded to patient feedback within the last 12 months. Patients could leave feedback via NHS choices and via the Friends and Family test (FFT). The practice had received 4 forms of patient feedback in the last 12 months via these methods. We were not provided with any actions taken against patient feedback within the last 12 months at the time of inspection. The practice had previously implemented a new telephone system in response to patient feedback during the COVID-19 pandemic regarding patient access and call waiting times. The practice had developed an action plan to reintroduce a Patient Participation Group (PPG). At the time of inspection, information on relaunching the PPG with further social media links was available on the practice website. The practice had plans in place to upload patient surveys and questionnaire tools to help improve feedback to shaping the service along with frequently asked questions for guidance to patients. 	

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
<ul style="list-style-type: none">• We saw examples of meetings minutes which showed the learning outcomes shared in relation to significant events.• The practice showed us documented audits that demonstrated quality improvement amongst clinical staff practice, including medicine management clinical activity through the dispensary.• We looked in detail at the practices policies and procedures in relation to clinical care such as infection control, health and safety and emergency procedures. We also reviewed a number of protocols relating to clinical procedures including handling specimens and care of vaccines. There were policies and procedures for safe working practices such as COSHH (Control of Substances Hazardous to Health) and these were reviewed accordingly. The practice had amended processes where the latest guidance was available or through reflective practice from internal performance audits to drive service improvements.• The practice took a proactive approach to drive a partnership with the practices within the primary care network (PCN). At the time of inspection, the practice manager was transitioning their role into a PCN project lead. There was a project plan in place to streamline governance arrangements among the practices within the PCN for shared 'best practice', such as policies, procedures and audits. PCN leadership meetings were in place to discuss future improvement planning.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands. The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

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

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

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

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

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

Glossary of terms used in the data.

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