

Care Quality Commission

Inspection Evidence Table

Hartland Way Surgery (1-547564741)

Inspection date: Remote Records Review on 4 July 2022 and Site Visit on 8 July 2022.

Date of data download: 28 June 2022

Overall rating: Good

Following our previous inspection on 19 May 2021, the practice was rated as Requires Improvement overall (requires improvement in safe, effective and well-led) for issues in relation to recruitment checks, safety systems and records, infection prevention and control, medicines management, identifying patients with commonly undiagnosed conditions, uptake for childhood immunisations and cervical screening and effective staffing. In this inspection, we found that the provider had addressed these issues.

Safe

Rating: Good

During the last inspection in May 2021 the practice was rated as requires improvement for providing safe services for issues in relation to recruitment checks, safety systems and records, infection prevention and control and medicines management; In this inspection, we found that the provider had addressed these issues and the practice was rated as good for providing safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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

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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y
There was a fire procedure.	Y
Date of fire risk assessment: 22 June 2022 Actions from fire risk assessment were identified and completed.	Partial ¹
1. Following the fire risk assessment, the provider had reviewed the remedial actions and had addressed most of the actions; they had a detailed action plan and were working towards addressing the remaining actions and we saw evidence to support this. The provider had not undertaken any fire drills since June 2021; during the inspection, the provider informed us that fire drills would be undertaken on a six-monthly basis.	

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: 28 September 2021	Y
The practice had acted on any issues identified in infection prevention and control (IPC) audits.	Partial ¹
The arrangements for managing waste and clinical specimens kept people safe.	Y
1. The practice had addressed most of the recommended actions following the IPC audit and were working towards addressing the remaining actions.	

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

Information to deliver safe care and treatment

Staff had 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

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.67	0.66	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	7.6%	9.2%	8.8%	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	5.17	5.45	5.29	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
infection (01/10/2021 to 31/03/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	96.8‰	60.4‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.45	0.55	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	2.4‰	4.7‰	6.8‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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.	Y ¹
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

Medicines management	Y/N/Partial
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.	Partial ²
<p>1. During the inspection, we found that all patients taking Methotrexate (a medicine used to suppress the immune system), Azathioprine (a medicine used to suppress the immune system), Leflunomide (a medicine used to treat inflammatory conditions) and Warfarin (a medicine used to thin blood) had the required monitoring.</p> <p>During the inspection, we reviewed the records of five patients taking ACE Inhibitors or angiotensin II receptor blocker (medicine used to lower blood pressure) who have not appeared have the required monitoring; we found that that the practice were aware of these patients and were regularly recalled.</p> <p>2. During the inspection, we found two vaccines in the medicines fridge which expired in June 2022; the provider discarded these medicines immediately and checked the remaining stock.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong/did not have a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	6
Number of events that required action:	6

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

Event	Specific action taken
Two urgent tasks were not flagged on the patient management system and were not dealt with in a timely manner.	<ul style="list-style-type: none"> A non-clinical member of staff found this issue and dealt with it immediately. This incident was discussed with staff and they were alerted to ensure urgent tasks were marked and dealt with in a timely manner.

A medicine was not available during a patient's appointment.	<ul style="list-style-type: none"> • The provider discussed this with the patient and was booked in for an appointment another day for the administration of medicine. • A revised stock checking and ordering process was introduced following this incident.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y

Effective

Rating: Good

During the last inspection in May 2021 the practice was rated as requires improvement for providing effective services for issues in relation to identifying patients with commonly undiagnosed conditions, uptake for childhood immunisations and cervical screening and effective staffing; In this inspection, we found that the provider had addressed these issues and the practice was rated as good for providing effective services.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice 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">• 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.• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

- All patients with a learning disability were offered an annual health check. The practice had 18 patients with a learning disability, and all had received an annual health check in 2021/22.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

During the inspection:

- We reviewed the records of two patients with a potential missed diagnosis of diabetes and found they were appropriately reviewed and monitored.
- We reviewed the records of five patients with diabetic retinopathy with HbA1c more than 74mmol/l. We found that three patients had been reviewed in the last year and the remaining two patients had been recalled.
- We reviewed the records of five patients with a potential missed diagnosis of chronic kidney disease (CKD) and found they were appropriately reviewed and monitored.
- We reviewed the records of five patients with CKD and found these patients were under secondary care and were monitored appropriately.
- We reviewed the records of five patients who had not had their thyroid monitoring in the last 18 months and found that their thyroid function tests and medicines review were overdue; however, the provider were aware of these patients and they had been recently recalled.
- We reviewed the records of five patients who had been prescribed 12 or more SABA (short acting beta agonist) inhalers for asthma and found that for one patient their asthma review was slightly overdue.
- We reviewed the records of five patients with asthma who had received two or more courses of rescue steroids and found no concerns with review and monitoring.

- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	35	41	85.4%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	20	23	87.0%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	20	23	87.0%	Below 90% minimum
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)	21	23	91.3%	Met 90% minimum
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)	36	45	80.0%	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

To improve uptake of childhood Immunisations the provider informed us that they recalled patients on a monthly basis; if parents did not respond on three occasions the practice nurse contacted them to find out their concerns. They informed us that they were undertaking the following actions to improve uptake of childhood immunisations:

- Continue to advise patients on the benefits of childhood immunisations.
- Continue the process of call and recall.

The provider had plans to create information sheets to available through their new website and involve their patient participation group to try and understand the reasons why parents would not want their children to be vaccinated.

Unverified data for 2021 – 2022 provided by the practice indicated they had achieved 97% to 100% uptake for childhood immunisations.

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: 31/12/2021) (UK Health and Security Agency)	72.9%	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)	77.5%	52.3%	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)	78.4%	63.4%	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)	45.8%	52.8%	55.4%	No statistical variation

Any additional evidence or comments

To improve uptake of cervical screening the provider informed us that they recalled patients on a three-monthly basis; if patients did not respond on three occasions the practice nurse contacted them to find out their concerns. They informed us that in some cases, patients were referred to a specialist clinic. They informed us that they had created an article for patients on cervical screening which would be made available through their new website.

Unverified data for 2021 -2022 provided by the practice indicated they had achieved 78% uptake for cervical screening.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y

The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

The provider undertook 10 clinical audits and two quality improvement projects in the last two years, of which two were completed cycle clinical audits where improvements were implemented and monitored:

- For example, the provider had undertaken an audit to ascertain if methotrexate (a medicine used to suppress the immune system) had been prescribed appropriately. During the first cycle of the audit, the provider identified that only 83% of patients on this medicine have had the required monitoring and were prescribed appropriately and that 5% of patients were not coded with indications for using this medicine. Following the audit, the provider implemented a system to ensure these medicines were prescribed appropriately. In the second cycle of the audit, the provider identified that 100% of patients on this medicine had the required monitoring and were prescribed appropriately and 100% of patients were coded with indications for using this medicine.
- The provider had undertaken an audit to ascertain if patients with a history of gestational diabetes had been monitored appropriately according to evidence-based guidelines. During the first cycle of the audit (March 2021), the provider identified 32 patients meeting this criterion and found that 16 patients had not had their HbA1c (glycated haemoglobin) test in the last 12 months. Following the audit, the provider added this group of patients to their annual recall register, contacted all the 16 patients and provided them with a form for HbA1c testing; they discussed the findings in a clinical meeting to remind staff the importance of coding newly diagnosed gestational diabetes patients. In the second cycle of audit (March 2022), the provider identified 28 patients meeting this criterion and found that 24 patients had been contacted for the HbA1c test in the last year and 18 patients had their test in the last 12 months. This was an improvement when compared to the first cycle. Following this audit, the provider implemented a system for reception staff to contact patients who had not taken up their offer for the test and offer an appointment to discuss with a clinician; they had also updated their recall register to include all eligible patients.
- The provider undertook a quality improvement project on diabetes management in the practice due to the diabetes care being affected during the pandemic; as part of this, they reviewed their diabetes care processes and introduced the following:
 - A medical input diabetes clinic from a GP with special interest to support the practice nurse.
 - Medicines optimisation for patients with diabetes and other co-morbidities by Primary Care Network (PCN) Clinical Pharmacists and Technicians.

The provider informed us that this proposed project was discussed with their local diabetes commissioners and primary care network directors and all the member practices and a diabetes support team within the PCN was proposed and agreed.

The provider informed us, this would enable them to focus on the holistic care processes and help them interact with patients with cultural barriers and to offer them timely support.

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

Coordinating care and treatment

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

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

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,	Y

for example, stop smoking campaigns and tackling obesity.	
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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.	Partial ¹
1. The provider did not have the signed copy of the DNACPR form in the patient's notes; however, they maintained a record of the decisions made and consent obtained in their patient management system.	

Well-led

Rating: Good

During the last inspection in May 2021 the practice was rated as requires improvement for providing well-led services for issues with governance arrangements; In this inspection, we found that the provider had addressed these issues and the practice was rated as good for providing well-led services.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	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

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

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y

The practice had access to a Freedom to Speak Up Guardian.	Partial ¹
Staff had undertaken equality and diversity training.	Y
1. The provider had access to a freedom to speak up guardian; however, most of the staff we spoke to were not aware of who they were.	

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

Source	Feedback
Staff Interviews	<p>Staff we spoke to during the inspection told us:</p> <ul style="list-style-type: none"> • They were happy to work at the practice and supported by the partners and the practice manager. • They worked well as a team. • They respected each other and communication is good. • Communication had significantly improved since the last inspection.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Managing risks, issues and performance

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

	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.	Y
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

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	Y

were delivered.	
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 (PPG).	Y ¹
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
<p>1. The provider informed us that they had been recruiting PPG members since the last inspection who could attend in-person and virtual meetings. They had re-established the PPG and had their first meeting in December 2021 since the pandemic; it was agreed to have two PPG meetings a year.</p>	

Feedback from Patients

During the inspection we asked the practice to include a weblink to **CQC Give Feedback on Care** on their website; the provider sent this link to the patients via a text message requesting them to send us their feedback. We received feedback from 51 patients during the inspection. Feedback from 33 patients were negative and for the remaining 18 patients their feedback was mixed. Please see the themes below:

- 16 patients reported difficulty in accessing the surgery by phone.
- 22 patients reported they were not provided with a face to face appointment and was provided with a telephone appointment.
- Four patients reported they do not like telephone consultations and two patients were positive about telephone consultations.
- 19 patients reported difficulty in obtaining emergency appointments,
- Six patients reported they had to wait three to six weeks to obtain regular appointments.
- 12 patients were positive about the attitude of clinical and non-clinical staff and support from the practice; two patients were negative about the attitude of clinical and non-clinical staff.

During the inspection, the provider shared with us the complaints they had received in the last year and none of these complaints were related to access to appointments.

In response to the feedback we received, the provider sent the following:

- They recently undertook an access programme, which included an overview of the busiest times for the practice to understand if they had appropriate staff cover. The provider informed us that they were in the process of employing additional staff to help fill gaps identified by this programme.
- All routine appointments were offered as either face to face or telephone appointments.
- Emergency appointments were telephone appointments, which were reviewed by the GPs before the start of each session and face to face appointments were offered if required. They also offered face to face appointments after a telephone consultation when required.
- Patients were offered extended access appointments if on the day appointments were not available.
- To improve access to routine appointments they constantly reviewed appointment availability and where possible offered additional routine appointments.

Feedback from Patient Participation Group.

Feedback

During the inspection we spoke to a member of PPG; please see below their feedback about the practice and the projects they were involved:

- The practice contacted patients in November 2021 and recruited six new PPG members who attended the first meeting in December 2021.
- They were happy with the care and support from the practice and informed us that the practice staff, including clinical and non-clinical staff were approachable and very committed and involved in the PPG.
- The PPG member submitted articles in relation to the practice to the local resident's association which was circulated to over 1800 residents. For example, an article related to the role of the social prescriber was circulated.
- The practice was keen to fully involve the PPG in developing a number of projects which would benefit both the practice and the patients and that all PPG members submitted ideas for consideration.
- Two projects were selected:
 - Producing a concise electronic booklet as a source of information about the services and support provided by the practice. The PPG member shared with us a draft version of the booklet.
 - A review of how the practice communicated with older patients and to identify patients who may not have access to a mobile phone, internet and social media; they envisaged to support these patients by calling them and/or helping them in the waiting area and try and help people get online.
- The PPG members undertook a telephone answering project, where for a number of days each PPG member made various calls throughout the day and recorded the time taken to reach and speak with a receptionist. The data was forwarded to the practice manager for collation.
- The PPG members attended a webinar on PPG - Reset, Refocus and Recruitment which they said was very informative.

Continuous improvement and innovation

There were 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
The provider had improved systems and processes for the issues identified in the last inspection. For example, the management of patients with high risk medicines and in identifying patients with commonly undiagnosed conditions.	

Examples of continuous learning and improvement

- The provider had developed a new website which they said was more user friendly and informative for the patients and would go live in July 2022; during the inspection, they shared with us a test version of the new website.
- The provider conducted a learning disability engagement event as part of their quality improvement programme. The aims of the programme were:
 - Improve health and social care for people with LD and autism (LDA)
 - Reduce health inequalities for people with LDA
 - Health inequalities are unfair and preventable differences in health
 - Stop more people from dying too soon by making care better

The event was hosted in a local church and members from other stakeholder and other local GP practices attended the event; feedback from the primary care network clinical leads, commissioners and patients were positive about the event. The topics covered in the event included living alongside with learning disability, positive patient experience and employment insights

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.