

Care Quality Commission

Inspection Evidence Table

Eagle House Surgery (1-565401534)

Inspection date: 22- 24 March 2022 and 6 April 2022

Date of data download: 21 April 2022

Overall rating: Good

At our previous inspection on 9 November 2020 we rated the practice as good for safe, caring and well led and requires improvement for effective and responsive. This gave the practice an overall rating of requires improvement.

At this inspection safe, caring, effective and well led was rated as good, but responsive remained as requires improvement. This gave the practice an overall rating of good.

At the November 2020 inspection, we issued a requirement notice for breach of Regulation 12 HSCA (RA) Regulations 2014 safe care and treatment, as we found the registered person had not done all that was reasonably practicable to mitigate risks to health and safety of service users receiving care and treatment. In particular, there had been a significant decline in performance for review of patients with chronic obstructive pulmonary disease (COPD) and cervical screening rates were below national targets. At this inspection, we were satisfied there had been adequate improvement and this requirement notice had now been met and as a result we re-rated the effective domain to good (please see below evidence tables for more details).

At the November 2020 inspection, we also issued a requirement notice for breach of Regulation 9 HSCA (RA) Regulations 2014 person-centered care. In particular, we found patient feedback as evidenced by the GP Patient Survey and from NHS Choices demonstrated the practice needed to improve access to the service; and make sufficient suitable appointments available to meet patient needs. At this inspection, although we found some improvement, we were not satisfied this requirement notice had been met, as a result the responsive domain remained as requires improvement (please see below evidence tables for more details).

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had appropriate safeguarding policies in place, and each identified the lead member of staff to whom concerns should be reported.• We saw that vulnerable patients were discussed in both multidisciplinary and practice meetings and that the practice maintained a vulnerable patient register.• All patients identified as vulnerable had alerts attached to their patient record which popped up when their record was accessed.• Systems were in place to ensure referrals made for vulnerable patients were followed up and patients received their appointments• Information regarding the availability of chaperones was posted throughout the premises and available on the practice website. We saw evidence that staff had been trained in chaperoning duties, with patients' records noting when they were present during consultations.	

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 Public Health England (PHE) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• We reviewed staff files, all of which evidenced necessary pre-employment checks had been conducted and appropriate ongoing records were being maintained.• Detailed records setting out staff members' immunisation status were maintained and monitored.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: September 2021	Y
There was a fire procedure. Date of fire risk assessment: September 2021	Y
Actions from fire risk assessment were identified and completed.	Y

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: February 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had implemented national COVID-related Infection Prevention and Control (IPC) guidance. We saw the practice's IPC policy which included guidance on sharps and waste management and disposal and the cold chain procedure. • All staff had been given IPC training appropriate to their role and responsibilities. All mandatory training requirements were monitored and there was system to highlight when any refresher training was due. • The practice had adequate supplies of PPE. The premises were stocked with adequate supplies of liquid soap and paper towels. There were hand sanitiser dispensers throughout, together with clear guidance on hand hygiene and COVID control measures. We saw the cleaning being carried out at several times during the day. • We saw evidence that the provider carried out water temperature monitoring and sample testing in accordance with legionella control measures. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">We saw rotas for clinical and administrative staff were prepared in advance to ensure appropriate cover was in place to meet service demands. There were written induction processes for GPs, nurses and administrative staff. There was an adequate induction pack for locum GPs. All clinical staff had up to date sepsis training and all administrative staff had received sepsis awareness training, which we confirmed in discussions with them. Printed guidance was posted throughout the premises. The practice had a medical emergency policy, and all staff had received annual refresher training in basic life support.	

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

Appropriate and safe use of medicines

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

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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.58	0.54	0.76	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). (01/01/2021 to 31/12/2021) (NHSBSA)	8.5%	10.7%	9.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2021 to 31/12/2021) (NHSBSA)	5.43	5.78	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	76.3‰	60.1‰	129.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	0.79	0.60	0.62	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	6.6‰	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

Medicines management	Y/N/Partial
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
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 Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Patients medicines reviews, including the prescribing of high risk medicines, were carried out by GPs along with a pharmacist. • There was a local system used by the practice to monitor high risk medicines and antimicrobial prescribing. • The practice had a policy relating to emergency medicines, and we saw evidence supplies kept at the premises and for use by GPs on home visits were monitored on a regular basis. • The practice had also embedded software safeguards within the clinical records system to facilitate safe prescribing. This included a dashboard for warfarin and other high-risk drugs and safety alerts; • Our inspection of the practice fridges showed medicines were appropriately stored and fridge temperatures were appropriately maintained and recorded. We saw no instances of the temperature being recorded as too high or too low. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
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: 15	Y
Number of events that required action: 15	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> All significant events were reviewed, discussed and properly actioned, to demonstrate learning and improvement. The policy was accessible on all computers, together with the incident reporting and analysis forms. We saw evidence of events being reviewed and discussed at staff meetings, with learning points being disseminated appropriately. 	

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

Event	Specific action taken
A message was sent to the administrative team to book a patient in for a follow-up appointment with a female clinician. The message was not seen and the patient was booked in with a male clinician. Patient was unhappy.	The practice carried out an investigation and apologised to the patient. The administrative staff involved was given further training, and all staff was reminded the importance of checking patient notes before booking an appointment.
Clinician accessed the wrong patients notes and prescribed medication. The error was noted and rectified prior to patient collecting medicine	Clinician provided further training on using the system database. All staff reminded to double check the patients details before accessing their records.

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We reviewed a safety alert issued in 2016 which highlights the importance in monitoring blood electrolytes in patients taking both potassium-sparing diuretic and an angiotensin converting 	

enzyme inhibitor (ACEi) or an angiotensin receptor blocker (ARB) as it may lead to heart failure. We were satisfied that the above alert was recorded and actioned appropriately. We found all patients who were affected by this safety alert were consulted with and had the appropriate monitoring in place.

Effective

Rating: Good

We re-rated the effective domain from requires improvement to good, this was because we were satisfied adequate improvement had been made in the care and treatment for patients with COPD, and there was also improvement in the practice's cervical screening uptake rate.

QOF requirements were modified by NHS England 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

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. 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.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- At the previous inspection in November 2020, we found the practice was performing lower than local and national averages for care provided to patients with COPD. At that time we used QOF indicators to make our judgements, however, due to pandemic the CQC has currently suspended using QOF data to form our decision making. Instead, at this inspection we reviewed all patients on the practice COPD register, and reviewed how their COPD was being monitored, treated and managed. We were satisfied all patients were receiving the correct care and treatment in line with national guidelines, and our previous concerns had all been addressed.
- We reviewed 25 records for patients diagnosed with other long term conditions such as diabetes, chronic kidney disease, hypertension and asthma, and were satisfied they were also being treated and managed appropriately in line with national guidelines.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

- 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.
- 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)	127	144	88.2%	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)	140	161	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)	141	161	87.6%	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)	138	161	85.7%	Below 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)	153	180	85.0%	Below 90% minimum

Any additional evidence or comments
<ul style="list-style-type: none"> The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for five of five childhood immunisation uptake indicators. However, the uptake rate for all five indicators was in line with or higher than local averages. The practice was aware it had not met the target, and explained due to the pandemic some patients were reluctant to come into the surgery and other patients refused for cultural reasons. The practice had an appropriate re-call system in place which included three attempts to contact patients. We also saw evidence clinicians contacted parents to educate and advise them to attend with their children.

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: 30/09/2021) <small>(Public Health England)</small>	75.4%	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) <small>(PHE)</small>	70.5%	47.4%	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) <small>(PHE)</small>	61.5%	57.2%	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) <small>(PHE)</small>	57.1%	54.6%	55.4%	No statistical variation

Any additional evidence or comments
<p>The practice's cervical screening uptake was below the 80% target. However, they had improved by 5% since our previous inspection. The practice uptake rate was also in line with or above local averages. The practice explained that many patients were reluctant to attend the surgery during the pandemic. The practice also provided us with unverified and unpublished data from their databases which was reviewed by our clinical team. This data showed 79% of women aged between 25-59 years and 86% of women aged between 60-64 years had undergone a cervical cancer screening procedure.</p>

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

Any additional evidence or comments

At our previous inspection in November 2020, we found the practice did not have written policies or procedures to assist in limiting unplanned admissions, and follow-up on patients following release from hospital to prevent re-admissions to hospital. At this is inspection, we were provided with evidence of written procedures for the same.

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

We were provided with confirming evidence which showed the practice had carried out multiple clinical and non-clinical audits in the past two years. We reviewed a sample and were satisfied the audits demonstrated improvement.

Atrial Fibrillation Audit

The aim of the audit was to assess whether patients who had been coded as having Atrial Fibrillation (AF) had received the correct treatment.

In the first cycle five patients had been identified as being coded with AF, but were not being treated. The practice carried out a consultation with all five patients and referred them for an Electrocardiogram (ECG) to assess whether they needed further treatment.

In the second cycle the same audit was run, the five patients from the first cycle were all now being treated with anticoagulation medicine to manage their AF. One additional patient was identified with AF but had not been treated. This patient was referred for and ECG and thereafter also prescribed with anticoagulation medicine.

Non-steroidal anti-inflammatory drugs (NSAIDs)

Research showed patients over the age of 65 prescribed NSAIDS are at higher risk of Gastrointestinal (GI) bleeding. To reduce this risk these patients should be co-prescribed Proton Pump Inhibitors (PPI).

The aim of the audit was to assess how many patients over the age of 65 were being prescribed NSAIDS without a co-prescription of a PPI.

In the first cycle 20 patients were identified at risk. The practice re-called all 20 patients to review their prescription and where possible co-prescribe NSAIDS with PPI.

In the second cycle, 19 out of the 20 patients had been reviewed and were all now being co-prescribed both medications. The outstanding patient had been recalled several times but had not responded to the practice. There were no new patients identified at risk.

Effective staffing

The practice was able 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, for example, stop smoking campaigns and tackling obesity.	Y

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed five patients at random who were terminally ill or receiving palliative care. We found all five patients had DNACPR conversations with their clinician(s) and their wishes were adequately recorded.</p>	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Patient feedback	
Source	Feedback
Patients interviews	We spoke to 22 patients. All of the patients were positive about the care and treatment they received.
Online review	We reviewed comments across various online feedback platforms. In general, the comments positive about the care and concern received.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	90.9%	88.1%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	90.6%	86.4%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and	96.8%	94.6%	95.6%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	66.9%	81.1%	83.0%	Tending towards variation (negative)

Any additional evidence or comments

The practice was aware it had scored lower than local and national averages for the GP patient survey question regarding the overall experience at the GP practice. The management told us they are working with the PPG to help improve patient experience. The practice has introduced a new online consultation platform for minor ailments, it has increased clinical and non-clinical staff and introduced a new telephone system. The practice also carried out their own survey in early 2022, the results indicated 75% of patients responded positively to the overall experience at their GP practice.

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

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
Interviews with patients.	All 22 patients we spoke with were positive about their involvement in decisions about care and treatment.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	90.7%	91.4%	92.9%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice carers register contained 309 patients, equivalent to over 1% of the practice population.
How the practice supported carers (including young carers).	The practice sought to identify carers, and patients with carers, at the time of registration and opportunistically during consultations. There was a carers Information board in reception which signposted carers to local support groups. Carers were offered annual flu immunisations.
How the practice supported recently bereaved patients.	GPs write and sometimes visit the family. In addition, families were signposted to local sources of support.

Privacy and dignity

The practice respected / did not always respect patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Requires Improvement

At the previous inspection in November 2020 we rated responsive as requires improvement. This was because patient feedback as evidenced by the GP Patient Survey and from NHS Choices demonstrated the practice needed to improve access to the service; and make sufficient suitable appointments available to meet patient needs. At this inspection, although we found some improvement since the last inspection, the latest GP patient survey results, online reviews and patients we spoke with indicated further improvement to access was still required, as a result the responsive domain rating remained as requires improvement.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs, however there was still dissatisfaction with access to the practice (see access section below for more details)

	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: The practice was aware of dissatisfaction for appointment times and telephone access, new measures have been put in place to try and address these issues, however patient satisfaction in relation to access is still below an adequate standard (see below access section for more information).	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:30am – 6:30pm and pre-booked extended hours to 7:30pm.
Tuesday	8:30am – 6:30pm and pre-booked extended hours to 7:30pm.
Wednesday	9am – 6:30pm and pre-booked extended hours to 7:30pm.
Thursday	8:30am – 6.30pm
Friday	8:30am – 6.30pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- 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.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available Monday and Wednesday until 7pm 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.
- Additional extended hours service appointments could be booked at other sites within the local area commissioned by the local CCG. Appointments could be booked weekdays between 4pm – 8pm and weekends 8am to 8pm.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

People were not always able to access care and treatment in a timely way.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Partial
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	Partial
There were systems in place to support patients who face communication barriers to access treatment	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

National GP Patient Survey results

Indicator	Practice	CCG average	England average	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 (01/01/2021 to 31/03/2021)	33.1%	N/A	67.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	42.3%	69.2%	70.6%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	57.2%	66.2%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	73.5%	79.3%	81.7%	No statistical variation

Any additional evidence or comments

- The management was aware of on-going patient dissatisfaction with access to the practice, in particular telephone access and experience of making an appointment. The practice told us it had had installed a new telephone system so that the volume of telephone calls and the response times can be better monitored. It had also increased the number of staff answering the telephone lines. To help reduce the number of people calling the practice an online consultation platform for minor ailments and queries was introduced. To increase the range and number of appointments the practice has recently tried to recruit more clinicians but have been unsuccessful. The practice told us about their action plan to further improve access, this included re-reviewing the telephone system and increasing both clinical and non-clinical staff.

Telephone access

- The results of the latest GP Patient Survey (above), has slightly improved since the last inspection, but there was a continued level of patient dissatisfaction for phone access to the practice: 33% of patients were satisfied with how easy it was to get through to someone by phone. This is an improvement since the last inspection (25% at that time) but still well below the national average of 67%.
- On the day of the inspection, we spoke with 22 patients, 15 of the patients confirmed it was still difficult to access the practice via telephone, often with long call waiting times.

Appointments

- The results of the latest GP Patient Survey (above) showed 42% of patients responded positively to the overall experience of making an appointment. This is a very slight improvement since the last inspection (41% at that time) and still well below the national average of 70%.
- On the day of the inspection, we spoke with 22 patients, 15 of the patients confirmed it was difficult getting through to the practice on the phone to make an appointment, and there was often long queues at the reception. Some patients were positive about the new online consultation platform.

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.	16
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

Example(s) of learning from complaints.

Complaint	Specific action taken
Delay in sending patient copies of her medical records	Senior staff explained why there was a delay, spoke with patient and provided an apology, the records were sent to the patient a few days later.
Patient not happy with customer service from receptionist.	Senior staff spoke with patient, apologised and dealt with their query. Reception staff given further training on customer service.

Well-led

Rating: Good

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.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
Staff interviews	We spoke with several members of staff during the inspection. All stated they felt well supported and that they had access to the equipment, tools and training necessary to enable them to perform their roles well. We were told staff were given protected time to enable them to undertake training and carry out non-clinical duties. Staff reported there were good, effective working relationships between managers and staff and clinical and non-clinical staff.

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
Explanation of any answers and additional evidence:	
The practice had a suite of practice specific policies including, child and adult safeguarding, infection and prevention control and significant events. There was a system for these to be regularly reviewed by the management team.	

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
Explanation of any answers and additional evidence:	
<p>The practice had implemented an online e-consult service which allowed many queries and consultations to be carried out remotely. Patients could still visit the doctor if they preferred to have a face to face consultation.</p> <p>The practice was aware that some of its patient population was digitally excluded, and these patients were prioritised for face to face appointments.</p>	

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

Engagement with patients, the public, staff and external partners

The practice involved / did not 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.	Y
The practice had an active Patient Participation Group.	Y
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

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> PPG members told us the practice engaged well with the group and the feedback was positive. It recognised positive progress with the actions taken by the practice to improve patients' experience of the service.

Continuous improvement and innovation

There were 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:	
<p>In response to our previous inspection, the practice put in place an action plan to improve outcomes for patients with COPD and to increase the uptake of cervical screening. Clinicians ran specific reports and clinics to ensure patients diagnosed COPD and those due their cervical screening test were being called into the practice. At this inspection, we saw confirming evidence of improved outcomes for patients within both these clinical areas.</p>	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **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.
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- ‰ = per thousand.