

## Inspection Evidence Table

The Humbleyard Practice

(1-582002145)

**Inspection Date: 26 July 2023**

Date of data download: 24/07/2023

## Overall rating: Requires improvement

At our last inspection published 27 January 2017 we rated the practice overall as good. At this inspection we have rated the practice as requires improvement overall because;

- There had been significant growth of new housing in the past years within the practice area. Since 2010 the practice list size had grown from 14167 patients to the current list size of 21970. Data provided by the practice showed an increase of patients each month since January 2010. This had caused significant workload challenges for the practice to meet the clinical and non-clinical needs of patients. The practice continued to try and meet this challenge as there was a lack of other primary care provision in the area.
- There had been significant changes in the senior management team. A temporary practice manager was in place but had only been working at the practice for 24 days prior to our inspection.
- Prior to the inspection, the practice had recognised the need to review and change the strategy and structure of the practice and had developed a plan to achieve this. This plan had resulted in the leaders recognising that their staff morale was low, staff retention and recruiting was a challenge, and there was a high workload for all staff. They shared with us the detailed action plan that had been written but not yet implemented. The implementation of the re structure involved new senior management staff who had been recruited but had yet to start working at the practice. Each practice site manager had been involved but at the time of the inspection, other staff we spoke with told us they were aware changes were to happen but had not been involved in developing the strategy and plan. However, we found the practice did not have an action plan in place to ensure they had clear oversight and were not actively monitoring all risks, including backlogs of work such as dealing with correspondence.
- The practice had failed to demonstrate that good governance procedures were in place as some systems and processes failed to ensure risks were fully reviewed, documented, and monitored to drive safe and effective services and ensure all actions from risk assessments were completed.
- Staff morale and feedback was mixed, with positive comments about team working and the commitment to provide quality services to patients. However, they told us senior leadership engagement was inconsistent and lacked cohesion and there was poor communication across all sites and teams
- Data from the national GP Patient Survey and feedback from patients we spoke with showed satisfaction about access to the practice , including by telephone were lower than national averages.

## Safe

## Rating: Requires improvement.

At our last inspection published 27 January 2017 we rated the practice as good for providing safe services. At this inspection we have rated the practice as requires improvement because;

- The practice did not evidence clear monitoring of action plans such as infection prevention and control to ensure all actions were completed.
- Staffing levels compromised the practice ability to ensure backlogs of work did not occur for example managing workflow and coding of medical conditions.
- Within the dispensary, we found controlled drugs were not managed in line with national guidance and the practice policy.
- The system and process in place to ensure repeat medicines were prescribed and dispensed safely was unclear. Medicines were re authorised by GPs who told us they reviewed medicines but did not always record that a medicine review had been completed.
- The practice system showed some incidents and events were reported, investigated and learning shared, however, not all staff told us they would report all events. Practice meetings were held inconsistently and not all staff were invited which meant not all staff benefitted from the shared learning.
- A system was in place for recording safety alerts but there were gaps in the actions taken.

### 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.	P <sup>1</sup>
Date of last assessment: Various dates	Y
There was a fire procedure.	Y
Date of fire risk assessment:	Not known <sup>2</sup>
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 The practice had undertaken health and safety checks but could not demonstrate that actions had been taken to address concerns when these were identified. . The practice explained that each site continuously monitored their environment, although not always formally documented, to ensure it was safe for patients and staff, but the overall management team did not have clear oversight of this.</p> <p>2 The practice told us they had undertaken fire risk assessments in the past 2 years, but they failed to provide the practices to support this. Following the inspection, we were told that an external provider had been engaged to carry out these assessments again. We found the practice had undertaken some health and safety checks, for example fire safety equipment (November 2022), fire alarm and detection service (May 2023), emergency lights (March 2023). A fire drill had been undertaken in the past 12 months. We noted fire alarm tests were undertaken but this was done at irregular intervals with up one month between tests. A risk assessment had been completed including the management of legionella and regular water testing was completed. We saw that equipment used by clinical staff had been checked and calibrated appropriately.</p>	

## Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y <sup>1</sup>
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: November 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y <sup>2</sup>
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 All staff we spoke with were knowledgeable about infection prevention and control, training was managed at each site, and they told us staff were up to date. However, the senior management team did not have clear and easy access to this information to ensure all appropriate training was maintained.</p>	

2 The practice had engaged with the Integrated Care Board Infection and Prevention Team. However, the action plan that was developed alongside the audit was not well monitored. Although staff told us all actions had or were being completed, the action plan was not updated. We did not identify any IPC issues during our on-site inspections.

**Risks to patients**

**There were gaps in 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.	P <sup>1</sup>
There was an effective induction system for temporary staff tailored to their role.	P <sup>2</sup>
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.	P <sup>3</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1&amp;3 The practice told us staff retention and recruitment was a particular challenge. The practice had recruited new staff members but still had vacancies for both clinical and non-clinical roles. The turnover of staff had affected staff morale and caused higher a workload. Staff told us they worked together mitigate shortfalls, but workload backlogs had occurred, for example, dealing with correspondence and summarising of medical records. Access was proactively monitored but lack of clinical capacity sometimes resulted in the practice closing a site and reducing advance appointments.</p> <p>2 Whilst we saw induction documentation was used for new staff starting at the practice, we found this was not role specific. New staff we spoke with told us they had been supported by their colleagues and managers to undertake their new roles.</p>	

**Information to deliver safe care and treatment.**

**Staff did not have all the information they needed to deliver safe care and treatment.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. 1	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	N <sup>1</sup>
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	P <sup>2</sup>
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	P <sup>3</sup>
There was a documented approach to the management of test results, and this was managed in a timely manner.	P <sup>4</sup>

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	P <sup>5</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 There had been significant growth of new housing in recent years within the practice area. Since 2010 the practice list size had grown from 14167 patients to the current list size of 21970. Data provided by the practice showed an increase of patients each month since January 2010. This had caused significant workload challenges for the practice to meet the clinical and non-clinical needs of the patients. The practice had a backlog of medical records to fully summarise because they had prioritised current workflow such as coding of medical conditions from correspondence such as discharge letters. The practice reduced the risk of the summarising backlog as they accepted the electronic transfer of notes and staff kept a log of those patients who were identified as vulnerable or where safeguarding concerns were noted. We noted that this list was held on the practice intranet but not all staff were aware of it. The paper records were available should clinical staff request them.</p> <p>2 During the inspection we identified the practice had a backlog of reviewing, filing, and coding information from patient correspondence. The practice showed evidence that this backlog had been recently reduced, and they were continuing this work further. The practice took immediate action from our feedback and reviewed and amended the procedure for dealing with correspondence to ensure any risks from future backlogs were identified and escalated.</p> <p>3 The practice told us they undertook a regular search to ensure all clinical staff had actioned the referrals they had agreed with patients. A recent quality checked showed some referrals had been delayed but action had been taken by other clinicals staff to make the referral. The practice told us they had reviewed the patients and no patient had come to harm as a result of this delay. We were told that this would be addressed with the individual clinicians to identify any training needs.</p> <p>4&amp;5 During our inspection we identified that not all test results had been filed. Although we did not identify any results that had not been acted on, the system and process in place was not clear and increased the risk of results not being actioned and filed in a timely way. We found a test result from June 2023 and others that had not been filed more than 2 weeks after receipt. The practice took immediate action, reviewed, amended, and implemented the revised practice procedures to ensure all results were viewed and actioned within an appropriate timeframe.</p>	

### Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) <small>(NHSBSA)</small>	0.74	1.02	0.91	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). (01/04/2022 to 31/03/2023) <small>(NHSBSA)</small>	10.8%	9.8%	7.8%	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	5.88	5.79	5.23	No statistical variation

Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	114.2‰	194.8‰	129.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.67	0.88	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	8.1‰	12.0‰	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.	P <sup>1</sup>
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.	P <sup>2</sup>
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	P <sup>3</sup>
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	P <sup>4</sup>
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 <sup>5</sup>
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y <sup>6</sup>
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.	P <sup>7</sup>
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 <sup>8</sup>
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y

There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <p>1 Within the practice area, medicines were stored securely. However, the dispensary access at one site was restricted to authorised practice staff, but at the second dispensary allowed unsupervised staff access. Security cameras had been installed but these were not routinely monitored. The practice took immediate action to ensure only authorised staff had access or were present if unauthorised staff needed to gain access, for example cleaning or maintenance staff.</p> <p>2 The practice employed a wide skill mix of clinical staff; they told us and staff we spoke with confirmed they had easy access to GPs should they need advice. Some staff told us they had allocated time each session to go through any patients seen with a GP. However, the practice did not document these supervision sessions and there was no programme of protected time for clinical staff to proactively review cases and identify any learning needs.</p> <p>3 The system and process in place to ensure repeat medicines were prescribed and dispensed safely was unclear. In the dispensaries, the procedures did not specify which type of medicines needed authorisation by the GP before they could continue to be dispensed. An informal list was supplied to dispensers but was not comprehensive. The process for medication reviews was unclear. The practice told us GP reauthorised repeat medicines and although they told us they undertook a review of the medicines, they did not code this as a medicine review at that time. They told us they undertook full medicine reviews at other times and that these were sometimes undertaken by other clinical staff, for instance pharmacists. The practice data showed there was a backlog of medicines reviews fully completed and that had been coded within the medical record. For example, a clinical search identified 866 patients were prescribed 10 or more medicines and of these, 15% had not had a coded medicine review in the past 18 months, although the practice told us they reviewed medicines when reauthorising repeat prescriptions.</p> <p>4 The practice had a procedure for the processing of hospital discharge letters but there were no time frames associated with this and we were told until very recently there had been a significant backlog of letters waiting to be processed.</p> <p>5 The practice had systems and processes to ensure patients on high-risk medicines were monitored although it was not always clear from the documentation of any follow ups planned. For example, our clinicals searches found.</p> <ul style="list-style-type: none"> <li>• 108 patients were identified as having Warfarin prescribed and all had received appropriate monitoring.</li> <li>• 42 patients were identified as having been prescribed Azathioprine and 4 had not received monitoring in the past 6 months. We reviewed these records and found all patients had been reviewed, 1 was recognised as living out of area, 1 patient had not started taking the medicine and 1 had blood test planned and 1 had recently attended for blood testing.</li> <li>• 2445 patients were identified as taking an ACE inhibitor or Angiotensin II receptor blocker. Of these, 17 patients were identified as not receiving the required monitoring in the past 18 months. We reviewed 5 patients records and found 2 had planned blood test appointments but the other 3 were overdue.</li> </ul> <p>6 The practice had audited the use of hypnotics to try and reduce their use and support patients with non-pharmacological interventions. Patients taking high dose morphine had received a structured medicine review. However, Controlled Drug checks were not undertaken monthly as per policy and there was a gap between December 2022 and May 2023 for some medicines.</p> <p>7 Not all Controlled Drugs were denatured before disposal in line with current guidance.</p> <p>8 The practice had conducted an audit for broad spectrum antimicrobial use and to ensure safe prescribing.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	P <sup>1</sup>
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y <sup>2</sup>
<p>Explanation of any answers and other comments on dispensary services:</p> <p>1 Steroid Treatment Cards were unavailable at one dispensary site.</p> <p>2 Facilities at both dispensary sites did not ensure patient confidentiality at the hatches but clear signage was in place to tell patients that rooms were available if needed to conduct a private conversation.</p>	

**Track record on safety and lessons learned and improvements made.**

**The practice had a system to learn and make improvements when things went wrong. However, this was not wholly safe and effective.**

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.	P <sup>1</sup>
There was a system for recording and acting on significant events.	P <sup>2</sup>
Staff understood how to raise concerns and report incidents both internally and externally.	P <sup>3</sup>
There was evidence of learning and dissemination of information.	P <sup>4</sup>



Number of events recorded in last 12 months:	35
Number of events that required action:	35
Explanation of any answers and additional evidence: 123&4 The practice demonstrated there was a system and process for recording and investigating events that happened, and learning was shared with the staff via the intranet system and in practice meetings. However, some staff we spoke with told us they did not always raise issues because they were not confident actions would be taken. The practice recognised that staff meetings were held infrequently and told us they were challenged to meet as a whole practice team because of working across 3 sites.	

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

Event	Specific action taken
Patient requesting additional repeat medicines. The staff refused and referred to the GP. GP tried to contact patient but was unsuccessful and therefore did not issue medicine.	Feedback was given to the team that they had made the correct decision to report event to the duty doctor immediately. Practice reviewed the risk of patients requesting high risk medicines early.
Missing code for chronic kidney disease on patient medical records.	Practice reviewed patient and no harm to patient. GPs undertook search to identify any other patients who may be at risk from the missing code. An education session was set up for clinical staff regarding the management of chronic kidney disease.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P <sup>1</sup>
Staff understood how to deal with alerts.	P <sup>2</sup>
Explanation of any answers and additional evidence: 1&2 A system was in place for recording safety alerts but there were gaps in the actions taken. An alert issued in 2020 had not been actioned appropriately and the dispensary team were unaware of patient leaflets warning patients of the flammable risk of skin creams. We reviewed another alert about an increased risk for patients aged 65 years taking a higher dose of medicine. We reviewed patient records and found GPs had undertaken reviews with patients but a clear discussion about risks was not documented in 3 of those records.	

**Effective**

**Rating: Good**

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

## Effective needs assessment, care and treatment

**Patients' needs were 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
The practice prioritised care for their most clinically vulnerable patients.	Y

## Effective care for the practice population

Findings
<ul style="list-style-type: none"> <li>• Patients received a full assessment of their physical, mental and social needs.</li> <li>• Flu, shingles and pneumonia vaccinations were offered to relevant patients.</li> <li>• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li> <li>• Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. The practice had offered 5616 checks to eligible patients and 1598 (28%) had been completed by the practice and an external team working with the practices.</li> <li>• All patients with registered as having a learning disability were offered an annual health check. The practice had a register of 94 patients with a learning disability and 76% had received full annual reviews. They told us they had links with the community teams to encourage those patients that had not received a review to attend.</li> <li>• End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.</li> <li>• The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. The practice had been instrumental in delivering the COVID-19 vaccine to theirs and other practices patients.</li> <li>• The practice demonstrated that they had a system to identify people who misused substances.</li> </ul>

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorders.
- 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 an effective 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. The practice told us they used a recall system which called patients in during their birth month. This system ensured patients attended as few appointments as possible. We found most patients were followed up and monitored effectively. For example, our clinical searches identified 106 patients who had a coded diagnosis of chronic kidney disease stage 4 or 5. Of these 5 were identified as not having received the appropriate monitoring in the past 9 months. We reviewed these patients records and found 1 was not a registered patient and the other 4 patients been contacted and asked to make blood test appointments. We noted 2 patients had palliative care plans in place but 2 did not have any care plan in place. We also looked at patients who had a coded diagnosis of hypothyroidism. Our search identified 842 patients and of those 7 had not received the appropriate monitoring in the past 18 months. We reviewed 5 of these 7 patient records and found all 5 patients had been contacted and asked to make blood test appointments.
- 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 could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Our clinical searches identified that 14 patients may have had a missed diagnosis of diabetes. We looked at 5 of these records and found all patients had been followed up in a timely manner.
- 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.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	202	208	97.1%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	204	213	95.8%	Met 95% WHO based target

The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	204	213	95.8%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	204	213	95.8%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	261	282	92.6%	Met 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
The practice nursing team and administration team worked together to ensure parent/guardians had access to appointments that were convenient to encourage uptake of the children's vaccination programme. Nurses would make time to talk with parents/guardian if they had any concerns.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	70.9%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	79.6%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (12/31/2022 to 12/31/2022) (UKHSA)	75.9%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	50.0%	54.4%	54.9%	No statistical variation

Any additional evidence or comments
The practice team proactively encouraged patients to attend screening appointments for the cervical cancer screening programme. Early morning appointments were available for patients who found it difficult to attend during working hours. Clinicians proactively discussed concerns about the programme with patients. We noted that the practice did not have a cervical sample taking fail safe system in place to mitigate the risks of sample results not being received. Immediate action was taken to address this issue.

## 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 <sup>1</sup>
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice evidenced their programme of quality improvement work and shared 21 examples of work included looking at medicines such as safe use of antibiotics, high risk medicines, use of medicines used for patients with dementia and hormone replacement therapy.</p> <p>We reviewed the audit undertaken in September 2022 which looked at the patients prescribed anti dementia and/or antipsychotic medicine. The audit showed.</p> <ul style="list-style-type: none"> <li>• 15 patients with a diagnosis of dementia were identified as having been prescribed antipsychotic medicine, of which 7 were also prescribed medicine to treat dementia.</li> <li>• 9 out of 15 were under the care of the hospital and/or the medicine had been initiated by them.</li> <li>• 1 patient was no longer registered at the practice.</li> <li>• 5 of 15 patients taking antipsychotic medicine had not had a recent review by a GP. This was undertaken by 30 September including 1 of the 5 patients requiring a review was completed by a GP as part of a multi-disciplinary team meeting, to continue with the medicine and re assessment in a further 6 weeks.</li> </ul> <p>Following the review all patients were set for regular review and a care plan put in place.</p> <p>We reviewed a second audit about safeguarding and clear record keeping.</p> <p>Between 2 and 13 January 2023, the practice looked at a random sample of 50 consultations from appointments at the practice. Of the 50 records the audit showed:</p> <ul style="list-style-type: none"> <li>• 21 consultations had documented and coded the appropriate safeguarding issues/actions.</li> <li>• 27 consultations had not documented and coded the appropriate safeguarding issues/actions.</li> <li>• 2 consultations had not recorded details of the person who accompanied a child to their appointment.</li> </ul> <p>The recommendations and actions taken were.</p> <p>To share the finding and remind clinical staff of the importance to record accurate information and coding of records and to design a method to ensure all clinicians were prompted to document who accompanied the child to their appointment.</p> <p>A second audit cycle was undertaken between 5 and 16 June 2023. A further 50 consultations were reviewed, and it showed improvements had been made with 47 consultations completed appropriately. Individual</p>	

feedback was given to the clinicians who had not completed the documentation appropriately in the other 3 records.

### 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.	P <sup>1</sup>
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.	P <sup>2</sup>
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.	P <sup>3</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 Staff told us, and we saw that an induction template was used for new staff however, we found this was not always role specific.</p> <p>2 All staff we spoke with told us they had received an appraisal in the past 12 months, although some staff did not feel their appraisal was a positive experience. Some explained to us that appraisals were not undertaken regularly.</p> <p>3 We did not see evidence to show that poor performance was formally addressed. We were given evidence where some shortfall in timely clinical work was identified but it was unclear this was formally addressed.</p>	

### Coordinating care and treatment

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

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

**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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice worked with other health professionals such as social prescribers, community mental health staff and physiotherapists.</li> <li>• One of the practice staff members started up a wellbeing walk for patients.</li> </ul>	

**Consent to care and treatment**

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Y
<p>Explanation of any answers and additional evidence.</p> <p>Feedback we received from care home representatives was positive about the care the GPs and nurses showed to their patients. They told us DNACPR forms were discussed with the patient, relatives and carers to ensure the patient's choices were clear.</p> <p>DNACPR forms we reviewed were completed appropriately.</p>	

## Caring

**Rating: Good**

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.**

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

Patient feedback	
Source	Feedback
Healthwatch	There were 14 comments on the Healthwatch website, we saw that 7 comments had rated the practice 5 stars, 2 had rated 4 stars 3 had rated 3 star and 2 had rated the practice 2 stars. Comments included positive feedback about staff at the practice.
NHS.uk website formerly NHS choices	Since November 2022 there had been 5 comments posted. 1 rating the practice 3 starts and 4 rating the practice 1star. Some negative comments about the helpfulness of staff.
Patients we spoke with or had feedback from	Feedback we received from patients was mixed. Most comments about care shown by staff were positive.
Feedback from care home representatives	We spoke with representatives from care homes the practice provided services to. All comments received about care shown by the practice staff were positive.

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	83.1%	87.2%	85.0%	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	75.9%	86.4%	83.8%	No statistical variation



professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	93.2%	94.2%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	59.6%	74.7%	71.3%	No statistical variation

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

<b>Any additional evidence</b>
The practice had not undertaken their own patient survey but told us they used information such as the GP patient survey, complaints, feedback from social media, NHS choices and Healthwatch to understand their patients view. Information from these sources was used in areas such as appointment planning and clinical skill mix.

**Involvement in decisions about care and treatment**

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

	<b>Y/N/Partial</b>
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
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

**National GP Patient Survey results**

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

<b>Indicator</b>	<b>Practice</b>	<b>SICBL average</b>	<b>England</b>	<b>England comparison</b>
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 (01/01/2023 to 30/04/2023)	88.3%	92.0%	90.3%	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 had 257 (1%) patients registered as carers. The practice staff gathered information about patients caring responsibility during consultations and at registration but recognised they did not always code the records. The practice website contained an online form carers could complete and submit to the practice.
How the practice supported carers (including young carers).	Information relating to support for carers was available in the practice and staff would sign post patients to their social prescriber to ensure they were offered support that was available to help them.
How the practice supported recently bereaved patients.	The practice told us clinical staff would contact bereaved patients and make appointments at convenient times to ensure patients were supported during this difficult time.

### Privacy and dignity

**The practice respected patients' privacy and dignity.**

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

## Responsive

**Rating: Requires improvement.**

At our last inspection published 27 January 2017 we rated the practice good for providing responsive services. At this inspection we have rated the practice as requires improvement because.

- Patient satisfaction of easy access to the practice was low. All indicators within the GP patient survey (data collected January to March 2023 and published July 2023) relating to access had deteriorated and were in some areas significantly below the national average.
- Whilst the practice had made changes to try and address the low satisfaction, such as a new telephone hub system in June 2023, this had not increased patient satisfaction.

## Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y <sup>1</sup>
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 <sup>2</sup>
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
<p>Explanation of any answers and additional evidence:</p> <p>1 There had been significant growth of new housing in the past years within the practice area. Since 2010 the practice list size had grown from 14167 patients to the current list size of 21970. Data provided by the practice showed an increase of patients each month since January 2010. The practice continued to try and meet this challenge as there was a lack of other primary care provision in the area.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30 am – 6.30pm
Tuesday	8.30 am – 6.30pm
Wednesday	7 am – 6.30pm
Thursday	8.30 am – 6.30pm
Friday	8.30 am – 6.30pm
<p>Appointments were available at different times across all 3 sites. The practice told us that on occasions if clinical staffing capacity was insufficient, they closed one site for a morning or afternoon. All patients could be seen at any site should they require a face-to-face appointment.</p>	

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>• Patients had a named GP who supported them.</li> <li>• 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.</li> <li>• The practice liaised regularly with community services to discuss and manage the needs of patients with complex medical issues.</li> <li>• Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school.</li> </ul>

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice offered appointments with health care assistants and long-term clinic appointments from 7am on Wednesday mornings. Pre-bookable appointments were available to all patients at additional locations within the area, as the practice was a member of a GP network. Appointments were available Saturday and Sunday 10am until 1pm.
- 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 not always able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	N <sup>1</sup>
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	P <sup>2</sup>
Patients were able to make appointments in a way which met their needs.	P <sup>3</sup>
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <p>12&amp;3 The practice was aware of low satisfaction and frustration in getting access to the practice. Whilst the practice undertook regular reviews and pro-active planning to ensure capacity was maintained to meet patient demand, we were told challenges remained. Patients told us that getting through to the practice was their greatest area of low satisfaction. People told us when they did see or speak with clinical staff, they received a good service. The practice had implemented a central call hub to manage calls for all sites. Staff we spoke with told us this was compromised by a lack of staff and sharing of workload.</p> <p>The practice offered a range of appointments which included face to face, telephone and online consultations. From the telephone or online consultations, the clinical staff would book face to face appointments if needed.</p>	

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	15.3%	N/A	49.6%	Significant variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	32.4%	59.1%	54.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	35.9%	56.1%	52.8%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	57.9%	76.1%	72.0%	Tending towards variation (negative)

Patient feedback	
Source	Feedback
Healthwatch	There were 14 comments on the Healthwatch website, we saw that 7 comments rated the practice 5 stars, 2 rated 4 stars, 3 rated 3 star and 2 rated the practice 2 stars. Comments from the lower ratings referred to patients' frustration at delays in getting through to the practice and access to appointments.
NHS.uk website formerly NHS choices	Since November 2022 there have been 5 comments posted. 1 rating the practice 3 stars and 4 rating the practice 1 star. Some negative comments about the access to the practice and long waits.
Patients we spoke with or had feedback from	Feedback we received from patients was mixed. About access to appointments, patients told us they experience long delays on getting through on the telephone and in some cases getting call backs from the GPS.
Feedback from care home representatives	We spoke to representatives from some care homes the practice provided services to. The care homes gave positive feedback about the responsiveness of the clinical staff when they needed advice and patients seen.

### Listening and learning from concerns and complaints

**There was an inconsistent approach to managing complaints.**

Complaints	
Number of complaints received in the last year.	8
Number of complaints we examined.	3

Number of complaints we examined that were satisfactorily handled in a timely way.	0
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.	P
<p>Explanation of any answers and additional evidence:  The practice told us each site was responsible for dealing with complaints, however, we found the complaints log shared with us did not contain all the complaints that had been received and responded to. This did not give us assurance that there was clear oversight of the management, investigation and sharing of learning and outcomes. The 3 complaints response letters we reviewed did not contain any information for the patients to escalate their complaint should they find they were not satisfied with the practice response. Staff told us not all complaints, particularly verbal ones were recorded.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient booked with wrong clinician	Apology given to patient and staff reminder to be more vigilant when booking appointments.
Patient not aware of safety netting advice given by clinician	Patient failed to seek further medical attention. Patient reported they had not been told. Consultation records showed the GP had recorded that safety netting and steps to take were given to patient. Although complaint not upheld, clinician took learning to ensure patients have understood any instructions given to them.

## Well-led

## Rating: Requires improvement.

At our last inspection published 27 January 2017 we rated the practice good for providing responsive services. At this inspection we have rated the practice as requires improvement because.

- We recognised that prior to the inspection, practice had recognised the need to review and change the strategy and structure of the practice and had developed a plan to achieve this. This plan resulted from the leaders recognising that staff morale was low, staff retention and recruiting was a challenge and there was a high workload for all staff. The practice shared the detailed plan that had been written but not yet implemented. The implementation of the re-structure involved new senior management staff who had been recruited but had yet to start working at the practice. Each practice site manager had been involved but at the time of the inspection, other staff we spoke with told us they were aware changes were to happen but had not been involved in developing the strategy and plan. However, we found the

practice did not have a comprehensive action plan in place to ensure they had clear oversight and were not actively monitoring all risks, such as backlogs of work.

- The practice failed to demonstrate good governance procedures were in place as some systems and processes had failed to ensure risks were fully reviewed, documented, and monitored to drive safe and effective services and ensure all risk assessments were completed and actions monitored to ensure completion.
- Staff told us there was poor communication across all sites and teams, and senior leadership appeared non-cohesive and did not always engage effectively. Within the dispensary, we found controlled drugs were not always managed in line with guidance and practice policy.
- A system was in place for recording patient safety alerts but there were gaps in the actions taken.
- The system and process in place to ensure repeat medicines were prescribed and dispensed safely was unclear. Medicines were re authorised by GPs who told us they reviewed medicines but did not code a medicine review completed.

The practice system showed some incidents and events were reported, investigated, and learning shared, however, not all staff told us they would report all events however minor. Practice meetings were held inconsistently for all staff and therefore not all staff benefitted from the shared learning.

### Leadership capacity and capability

**Leaders had the capacity and skills to deliver high quality sustainable care but had yet to demonstrate the leadership to engage staff and implement the plan they had for improvement.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	P <sup>1</sup>
Staff reported that leaders were visible and approachable.	N <sup>2</sup>
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: 1&2 The practice shared the plan to restructure the management team of the practice. This was a detailed plan and involved the employment of new senior managers. A new business manager had been employed but had not at the time of the inspection started working at the practice. This comprehensive plan had developed with the site managers being involved but had not involved or been shared with all the staff. The delay with sharing was in part due to tragic circumstances beyond the leader's control. Feedback we received from staff was mixed about the leadership and how approachable they all were.	

### Vision and strategy

**The practice had a clear vision and credible strategy to provide high quality sustainable care. However, this was in plan and had yet to be started.**

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	P <sup>1</sup>
Staff knew and understood the vision, values and strategy and their role in achieving them.	P <sup>2</sup>

Progress against delivery of the strategy was monitored.	N <sup>3</sup>
Explanation of any answers and additional evidence: Each practice site manager had been involved but at the time of the inspection, other staff we spoke with told us they were aware changes were to happen but had not been involved in developing the strategy and plan.	

## 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.	P <sup>1</sup>
Staff reported that they felt able to raise concerns without fear of retribution.	P <sup>2</sup>
There was an emphasis on the safety and well-being of staff.	Y <sup>3</sup>
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 2 The practice did not evidence a centralised management system to ensure all sites worked consistently. Some staff told us, different site local management system had different arrangements to managing behaviour that was inconsistent with the vision and values. Staff reported that communication was poor, and some were not all knowledgeable about the details of the vision and values. All staff we had feedback from told us they worked hard to ensure patients received high quality care and treatment.</p> <p>3The practice undertook a staff survey in February 2023. The results showed that 48 staff members had responded. The practice used of 1 to 5 score with 5 being very positive.</p> <ul style="list-style-type: none"> <li>• 83% of the staff who responded scored the practice 3 or more for being happy at work.</li> <li>• 71% of the staff who responded scored the practice 3 or more for feeling valued.</li> <li>• 96% of the staff who responded scored the practice 3 or more for being comfortable providing feedback to managers or partners.</li> <li>• 68% of the staff who responded scored the practice 3 or more for how well the practice held the value of professionalism and work ethic.</li> <li>• 79% of the staff who responded scored the practice 3 or more for how well the practice held the value of compassion and kindness.</li> <li>• 75% of the staff who responded scored the practice 3 or more for how well the practice held the value to grow as individuals and teams supporting and encouraging each other.</li> <li>• 73% of the staff who responded scored the practice 3 or more for how well the practice held the value of candour.</li> <li>• 65% of the staff who responded scored the practice 3 or more for how well the practice held the value of being uplifting, giving each other respect, appreciation, and recognition.</li> </ul> <p>Staff we spoke with told us the survey had been undertaken but they had not received any feedback of the results.</p>	



The practice told us there had been some well-being event for staff, this included some yoga sessions, social events and following a traumatic event, the practice engaged a support agency for staff who would like to contact them.

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

Source	Feedback
Themes from staff questionnaires	There was poor communications across all teams and sites. Staff were proud of the individual teams working well together and supporting each other. Staff told us patients were at the centre of their work. The practice had experienced significant changes in staffing levels, leavers, recruiting and retaining new staff and this has had a significant impact on morale and well-being.

### Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P <sup>1</sup>
Staff were clear about their roles and responsibilities.	P <sup>2</sup>
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: 1&2 The practice failed to demonstrate good governance procedures were in place as some systems and processes failed to ensure risks were fully reviewed, documented, and monitored to drive safe and effective services and ensure all risk assessments were completed and actions monitored to ensure completion. For example, managing backlogs of work such as workflow and summaries. Feedback received from staff showed staff knew the safeguarding and infection prevention leads but some staff told us they were not clear which senior management and leaders took overall responsibility and action for other roles as it was not consistent across all sites.	

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	P <sup>1</sup>
There were processes to manage performance.	Y <sup>2</sup>
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	P <sup>3</sup>
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 There were some assurance systems which were regularly reviewed and improved, for example managing clinical indicators and risks such as high-risk medicines. However, there were gaps in other areas for instance backlogs of work including correspondence and managing risk assessments, infection prevention and control and fire risks.</p> <p>2 There were some systems in place for managing performance, meetings were held to discuss areas such as clinical indicators. However, some performance was not routinely monitored and managed for example medicines reviews.</p> <p>3 Some risks were monitored and managed but others such as actions delays in acting on correspondence had not been fully investigated and managed to mitigate any risks that the backlog may have on patient care.</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 <sup>1</sup>
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 The practice demonstrated they used quality audits to look at areas where the practice might make improvements.</p>	

### Governance and oversight of remote services

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

Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

**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.	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
We spoke with members of the PPG who told us that meetings had been held with the practice. The PPG members told us they hoped the meetings would become more regular and that the practice managers and GPs would work with them to share information and support for any improvements.

**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.	P <sup>1</sup>
Learning was shared effectively and used to make improvements.	P <sup>2</sup>
Explanation of any answers and additional evidence: 1&2 The staff told us they were encouraged to undertake training courses and developments but because of the staff shortages this was not always possible. Staff told us they were given protected time to undertake their training. Clinical staff told us they were supported through their professional registration re validation and appraisals.	

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

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

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

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

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

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

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

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

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