

Care Quality Commission

Inspection Evidence Table

Highcroft Surgery (1-542061967)

Inspection date: 28 November 2022

Date of data download: 25 November 2022

Overall rating: Requires Improvement

We have rated the practice as requires improvement overall as we found the management of patients' health conditions needs required strengthening to ensure they received the appropriate reviews and monitoring. We found the management of safety alerts was ineffective to ensure they were acted on in a timely manner to minimise risk.

Safe

Rating: Requires Improvement

We have rated the practice as requires improvement for providing safe services as we found the management of medicines and the actioning of safety alerts needed improvements to mitigate risks to patients.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> The majority of staff had completed the required level of safeguarding training relevant to their role and were clear on the procedure to follow if they had a safeguarding concern. We found a senior member of the clinical team needed to update their level of safeguarding training appropriate to their role. Staff demonstrated clear awareness of their responsibilities around reporting incidents if they suspected a concern. The practice had safeguarding leads for both adults and children and policies in place to support staff in the event of a safeguarding concern. Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks were in place for staff as part of pre employment checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had taken a multi-disciplinary approach to ensure they could create accurate and up to date registers of vulnerable patients. This included working with health visitors and other relevant community teams. A random sample of records viewed during the inspection confirmed they had effective registers in place that were monitored regularly. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There were clear recruitment policies and procedures in place, including details of the checks required for locum staff. We reviewed files and found recruitment checks had been undertaken prior to employment and included proof of identification, qualifications, references, immunisation status and the appropriate checks through the Disclosure and Barring Service (DBS). 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: October 2022	Y
There was a fire procedure. Date of fire risk assessment: November 2022	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had appropriate safety policies, which were regularly reviewed and communicated to all staff, including temporary staff. A premise and security risk assessment had been carried out in August 2022. The assessment had highlighted that there was insufficient light outside the premises which posed a risk to patients and staff. The practice was in the process of liaising with the council for resolution. Staff refresher 	

training had been provided to ensure patients with specific mobility needs were supported when leaving the premises.

- Calibration of equipment and portable appliance checks were undertaken regularly to ensure they were fit for purpose and were in good working order.
- Control of Substances Hazardous to Health (COSHH) risk assessments had been completed to identify potential risks to patients and staff.
- All staff were up to date with health and safety training. A training matrix was in place to help the management team monitor that all staff training was completed when due.
- Fire procedures were in place and there was weekly fire alarm testing. There were appointed senior manager who had the role of fire safety manager and a fire drill had been undertaken in November 2022.
- The practice had carried out a range of health and safety risk assessments. An action plan was in place and evidence was provided that actions were being completed. For example, a broken electrical socket had been found. This had been replaced immediately.

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: November 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • All staff completed the relevant infection control training for their role through the online training system in place. • Personal protective equipment (PPE) was available throughout the practice and we observed the general environment to be clean and tidy. • There were processes in place to manage clinical waste, monitor the changing of curtains at regular intervals and carry out relevant infection prevention audits. • Cleaning audits were completed on a regular basis to monitor the effectiveness of cleaning. An audit, completed in November 2022, detailed the areas that had been checked and any actions that had been identified for action. • The practice had an action plan in place to address concerns identified during the infection control audit. For example, cleaning schedules in toilets not signed and dated. The practice planned to speak with the cleaners to ensure this was actioned. • Policies, procedures and audit templates were in place for infection prevention and control and accessible to all staff. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • A rota system was in place to manage staffing and staff worked flexibly and had opportunities for overtime to cover absences. • All staff had undertaken basic life support training, and reception and administration staff who handled calls to the practice and arranged appointments with the clinical team were aware of potential red flag symptoms. Staff knew when to notify a GP or other clinicians with concerns. • The practice shared evidence to demonstrate that they had carried out a test of actions to be taken if a patient collapsed. The mock test showed the first response had taken three seconds to arrive. Actions from the test included ensuring all clinical staff were aware of where the wheelchair was kept and to ensure when an emergency situation arose, the oxygen and ECG machine were immediately brought to the clinicians. • Systems were in place to ensure emergency medicines and equipment was checked on a regular basis and staff had the appropriate equipment to deal with medical emergencies. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p>	

- The practice had a system in place for the management of referrals under the two week wait process. Monitoring processes were in place to identify patients who were referred using the two week pathway and to ensure the pathway was used appropriately.
- The practice had a system in place to ensure all test results and information relating to patients received was acted on appropriately and in a timely manner.
- During a review of the clinical system we reviewed a random sample of patients records and found referrals and test results had been acted on promptly and in accordance with best practice guidance.

Appropriate and safe use of medicines

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

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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	0.86	0.82	0.82	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). (01/10/2021 to 30/09/2022) (NHSBSA)	7.3%	7.8%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2022 to 30/09/2022) (NHSBSA)	4.48	4.59	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	92.2‰	130.1‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.40	0.49	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	6.2‰	6.2‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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 UKHSA guidance to ensure they remained safe and effective.	Y
<p data-bbox="57 1704 1533 1749">Explanation of any answers and additional evidence, including from clinical searches.</p> <ul data-bbox="105 1783 1533 2042" style="list-style-type: none"> <li data-bbox="105 1783 1533 2042">• During the review of the clinical system we carried out a search of patients on a high-risk medicine used to increase the amount of fluid passed from the body in urine, whilst also preventing too much potassium being lost. We found a total of 56 patients on these type of medicines and a further review identified 22 patients as potentially not having received the appropriate monitoring. We looked at a random sample of 6 records and found 3 patients' records had been coded as medication review completed, however there was no information to confirm what had been reviewed and overdue monitoring of the patients' health condition had not been identified during 	

Medicines management	Y/N/Partial
<p>the review. Further review of the records showed a letter from the hospital concerning a change to medicines had not been processed for 3 months and patients who had stopped taking the high risk medicine, still had it on the repeat prescription screen, which posed a potential risk of the medicine being reissued. We also found an abnormal blood test from April 2022 which showed a possible diagnosis of chronic kidney disease stage 3 had not been followed up to confirm this.</p> <ul style="list-style-type: none"> • We carried out a random search of patients who had received a medicine review. We reviewed 5 clinical records and found 3 medicines reviews had been coded, however there was no evidence that a review had taken place or the patient had been involved in the discussion. We found one patient on a specific medicine who had not been made aware of the increased risk of skin cancer following the issue of a safety alert. Further reviews showed a second patient who had been identified as having a long term condition should have had annual blood tests, but had not had this done since January 2021. • stWe found 42 patients were prescribed methotrexate, an immunosuppressant medicine used to treat inflammatory arthritis and some skin conditions. We reviewed a random sample of 5 records and found the day of the week for the medicine to be taken had not been added to the clinical record as recommended by a drug safety update issued in September 2020 to reduce the risk of the medicine being taken more frequently than required and we were unable to find shared care agreements in some of the records. Following the inspection, the provider sent us evidence to demonstrate the appropriate systems were in place to ensure the drug safety update was being followed and the day of the week the medicine was to be taken was on patients' records. • Emergency medicines and vaccines were appropriately stored and there were clear monitoring processes in place. • There were appropriate arrangements in place for the management of vaccines and for maintaining the cold chain. We saw fridge temperatures were routinely monitored and vaccines reviewed at random were in date and stored appropriately. 	

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:	3
Number of events that required action:	3
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a process for raising and investigating incidents and significant events. • The practice made us aware of an incident that had occurred in relation to patient correspondence. The practice had taken action to ensure patient records were complete and up 	

to date and address any further action identified. The practice had liaised with the ICB and CQC throughout the process. As part of this inspection we reviewed the practices audits and were assured appropriate actions had been taken. We saw there were systems in place for the practice to deal with incoming patient correspondence and test results.

- Staff we spoke with were aware of how to report and record significant events and reported an open and honest culture and felt encouraged to raise events to result in learning and improvement within the practice.
- The practice had made the CQC aware of an incident that had occurred. We were provided with evidence to demonstrate that a thorough investigation had taken place to identify what actions were required to mitigate future risk.

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

Event	Specific action taken
Medicine error	<ul style="list-style-type: none"> • Secondary care had provided the wrong information on the dosage of medicines required for a patient • Practice noticed error and issued appropriate prescription • Secondary care was notified of error • Discussed with clinical staff
Task for 2 week urgent referral sent to wrong department	<ul style="list-style-type: none"> • Staff on receipt of task forwarded to relevant department at the practice for action • Discussed with the clinical team to mitigate future risk • Discussed at staff meeting to share learning

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had a policy in place which outlined the process for monitoring and acting on safety alerts, which included alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). • The provider was unable to demonstrate that all relevant safety alerts had been responded to. We reviewed a safety alert that had been issued in December 2014, concerning an anti-depressant medicine and the potential risks to patients aged over 65 years of age on higher than recommended dosage. We found 3 patients on this medicine and on reviewing each clinical record we found the practice had tried to contact the patients in November 2022, but had been unable to speak with them, therefore none of the patients had been made aware of the potential risks. • We reviewed a safety alert that had been issued in December 2014, concerning patients prescribed a combination of medicines that can result in a reduction of the effectiveness of the medication used to prevent strokes and heart attacks. We found 5 patients on this combination of medicines. We reviewed a random sample of 3 patients and found attempts had been made to contact the patients on the day of inspection to discuss alternatives. • Following the inspection we received assurances that systems had been strengthened to ensure all safety alerts were reviewed on a regular basis to ensure all actions were completed and risks were mitigated. 	

Effective

Rating: Requires Improvement

We have rated the practice as requires improvement for providing effective services, as we found patients care and treatment was not monitored effectively to ensure they received the appropriate reviews.

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

Effective needs assessment, care and treatment

Patients' needs were not always adequately assessed, and care and treatment were not 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. ¹	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">We carried out a random sample of 5 patients on the asthma register that had been prescribed 2 or more rescue steroids in the past 12 months. We found patients had not been followed up following an exacerbation of asthma, as detailed in the NICE guidance, within 48 hours of an exacerbation and 1 patient had been prescribed the wrong dose and quantity of steroids.On reviewing the clinical system, we found 4 patients with hypothyroidism who had not had the appropriate monitoring completed in the last 18 months. We reviewed each patient and found patients' medicine reviews were overdue and long-term condition reviews were outstanding. We found patients continued to be issued prescriptions for medicines despite medication reviews	

being overdue. We also found 1 patient had not received the appropriate blood monitoring since 2016.

- The practice had implemented workflow, which was a systematic approach to process incoming clinical correspondence. Staff had been trained in this process and there were effective systems in place to regular monitor and audit the effectiveness of the system.
- The practice used a range of clinical templates to support the management of patients' conditions, which linked in with the latest clinical guidance.

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 with mental health problems were referred to the social prescribing team to provide information on local support available.
- 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 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

- On reviewing the clinical system we found 28 patients who had been prescribed 12 or more reliever inhalers for asthma in the past year. We reviewed a sample of 5 patient records and found 1 patient had had a recent review, 2 patients were under the care of a hospital consultant and 2 patients had not had their asthma reviewed in the past year.
- During the clinical searches we found 2 patients with stage 4 and 5 chronic kidney disease who had not received the appropriate monitoring in the past 9 months. We reviewed each clinical record and found 1 patient had not had recent blood pressure monitoring and 1 patient had not had renal function checks completed for over 12 months.
- We identified 4 patients who had a potential missed diagnosis of diabetes. We found 3 patients had not been coded correctly. We reviewed each clinical record and found 1 patient was coded as having prediabetes but actually had diabetes and had received a diabetic review and 2 patients had diabetes but this had not been coded and they had not been referred for eye screening.

- We found 73 patients with diabetic retinopathy whose latest HbA1c was above recommended levels. We reviewed a random sample of 5 records and found 3 patients were overdue diabetic and blood pressure monitoring, with 1 patient who had not had a blood pressure reading since 2016 and another patient had a raised blood pressure reading in March 2022 which had not been reviewed.
- The local diabetes nurse specialist supported the practice and worked with the practice nurse to review patients with complex diabetic needs. The practice also had established links with other specialist nurses such as the respiratory nurse to provide expert advice and support when required.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Adults with newly diagnosed cardio-vascular disease were offered statins.

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) (UKHSA COVER team)	127	139	91.4%	Met 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) (UKHSA COVER team)	107	114	93.9%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	107	114	93.9%	Met 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) (UKHSA COVER team)	107	114	93.9%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	113	129	87.6%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

The practice had a recall system in place to follow up on patients who failed to attend appointments. We were told that some patients frequently missed their appointments and the nursing staff would try and contact them to speak with them about attending for immunisations.

Cancer Indicators	Practice	SICBL 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: 30/06/2022) (UK Health and Security Agency)	78.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	54.8%	64.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	69.5%	67.7%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	55.0%	55.7%	55.4%	No statistical variation

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.

Any additional evidence or comments

The practice continually tried to encourage patients to attend for their screening appointments. Patients were followed up and offered another appointment if they failed to attend.

Monitoring care and treatment

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

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

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

The practice shared with us an audit they had carried out to review patients on a medicine used to treat inflammatory conditions and if they had been reviewed by a specialist in the last 12 months. The audit identified 2 patients. On review of each patient record, the practice found that the medicine had not been recently prescribed. The clinical pharmacist was asked to review the medicine with each patient and if not being used to remove from repeat prescribing screen.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had invested in their staff to ensure they were able to offer more support to patients. This included supporting nursing staff develop in a range of clinical areas and supporting registrars in their medical training. There was a mandatory training programme in place for staff which was monitored by the leadership team to ensure all staff had the appropriate knowledge to support them in their roles. 	

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
Explanation of any answers and additional evidence:	

- The practice had the PCN care home lead based at the practice. They liaised regularly with the community teams to ensure patients received the appropriate care and monitoring.
- The practice had a schedule of regular meetings in place with community teams to share information and discuss concerns.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had a health kiosk for opportunistic screening of patients when they visited the practice. A machine was in place which provided patients with height, weight, blood pressure and pulse rate options. The machine printed a ticket which detailed the results and this was entered onto the patient record. 	

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

Responsive

Rating: Not rated

Access to the service

People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on website telephone messages)	Y

Explanation of any answers and additional evidence:

- The practice had implemented eConsult for patients. Patients who had access to the internet were asked to complete an online form which was then triaged by the practice and allocated to the appropriate clinician for further action.
- The practice had 2 reception staff on the front desk to provide support to patients visiting the practice. There was a back office team of staff who answered phone calls and carried out a range of administration duties.
- To improve the services offered to patients, the practice had a GP in the back office on some days to support the administration staff in answering telephone queries. Staff told us this had been successful as patients received clinical advice immediately and provided the staff with more appointments to provide to other patients.
- Extended access was available Tuesday and Wednesday from 6.30pm to 8pm. This was for patients who were unable to attend the practice during normal opening hours.

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 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 (01/01/2022 to 30/04/2022)	27.7%	N/A	52.7%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	42.0%	59.5%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	45.1%	58.7%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	69.3%	74.8%	71.9%	No statistical variation

Any additional evidence or comments

We spoke with a range of staff during the inspection, who told us that the practice was continually trying to recruit staff, however the shortage of staff had impacted on the practice.

Source	Feedback
NHS UK	The practice had received 9 reviews in the past 12 months. A total of 8 comments related to access. 50% of the comments were negative in relation to access and being able to get an appointment. Positive comments related to the improvement of the phone system and helpfulness of staff.
Google reviews	16 google reviews in the past 6 months. The reviews highlighted the difficulties patients had in accessing the practice and using the eConsult service.
Care Homes	We spoke with 2 care homes registered with the practice. One of the care homes said they struggled to get through to the practice by telephone. We spoke with the nurse lead for care homes at the practice, who told us each care home had a bypass number to ensure they could speak with the practice quickly and would ensure that the care home providers were reminded of the number to use.

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The leadership team were aware of the challenges and had a realistic strategy and supporting objectives to respond to challenges as well as maintaining quality and sustainability. Regular meetings were held with staff to discuss improvements and share ideas. Staff we spoke with explained that the leadership team were visible and approachable. Staff described the practice team as supportive. The leadership team demonstrated a passion to tackle health inequalities and there were strong governance arrangements in place to improve care outcomes. Staff reported that they felt well led and part of a team. There was strong collaboration and support across the team and a common focus on improving the quality of care and people's experiences. Staff met regularly to discuss any issues or complex cases and to offer and receive peer support. A range of meetings were in place to discuss issue and share updates with staff. The practice had daily team 'huddles' each working morning. This enabled the leadership team to identify any areas that needed additional support and review staff capacity on a daily basis. 	

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There was a mutual vision among the GPs and staff to provide health and social care for the benefit of patients. 	

- The practice mission statement was to provide a high standard of responsive, safe, modern and innovative care, whilst ensuring staff were well trained, motivated and caring. This was supported by feedback we received from staff during the inspection.
- Staff we spoke with demonstrated clear understanding of the vision, value and strategy and applied this in their role.

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Quality standards were discussed at monthly management meetings along with other information such as incidents and complaints. • There was a strong emphasis on the safety and well-being of staff. One of the key objectives was to increase the number of staff at the practice. The leadership team had been continually trying to recruit staff to improve work/life balance of current staff. The practice was looking at different roles to provide more options to encourage people to apply to work at the practice. On speaking with a range of staff, they were aware that the leadership team were looking to recruit more staff to support the existing team. The impact of the shortage of staff had impacted on the morale of some of the staff, however we were told that the leadership team were supportive when staff faced difficulties. • Following a staff survey, the leadership team had a clinician working in the back office to provide clinical support to administration staff in answering questions from patients. The outcome of the survey showed staff agreed with this new way of working and on the day of inspection feedback from staff was positive about having the extra support of clinical staff when dealing with patient queries. • Staff were very positive about working at the practice. Staff told us they had received constant support from the GPs, manager and team. There was a positive attitude throughout the entire workforce. • Staff had clear roles and responsibilities and staff wellbeing was discussed as part of the appraisal process. • Staff were encouraged to report incidents and share learning. Staff told us there was a 'no blame' culture and staff were well supported when reporting incidents. 	

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

Source	Feedback
Staff	<ul style="list-style-type: none"> • Staff we spoke with said they were well supported and part of the team. • Support was available when required and staff felt they could approach any of the management team for advice and help. • Staff reported that they were proud to work at the practice and spoke highly of the culture and felt they were treated equally.

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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place. • Communication was effective and organised through structured, minuted meetings. Governance and performance management arrangements were proactively reviewed. • The leadership team ensured processes were co-ordinated and any changes were implemented through a team approach. There was an open culture and clear learning culture and the systems for reporting and investigating incidents and complaints were integral to the team to share learning. 	

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.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	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

Explanation of any answers and additional evidence:

- We found assurance systems needed strengthening to ensure patients' needs were met. These included the management of medicines and long term condition reviews.
- The practice had a systematic approach to managing risk. A range of risk assessments were in place and monitored on a regular basis by the leadership team.
- A system was in place to ensure all staff were clear on their roles and responsibilities. Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place.
- The leadership team ensured processes were co-ordinated and any changes were implemented through a team approach.

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

Explanation of any answers and additional evidence:

- A range of safety mechanisms had been implemented to ensure risks were mitigated. This included a comprehensive range of risk assessments to ensure patient safety.
- The practice had a clear and systematic approach to identifying learning and development needs to ensure learning was shared across the group. Regular meetings of teams were held to ensure information was disseminated effectively.
- Evidence provided by the practice showed that monitoring of appointment activity was in place. We found the practice had increased the number of face to face appointments available following the COVID-19 pandemic.
- Regular clinical quality meetings were held to review audits, safety alerts, significant events and any updates to recommended clinical guidelines, however we found during the inspection that some safety alerts had not been acted on and patients with long term conditions had not received regular reviews.

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Evidence provided by the practice showed that 94% of patient clinical records had been summarized. An audit of 50 notes had been completed, by the practice, to ensure they had been summarized appropriately. The audit showed each set of notes reviewed had the details required. 	

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There was a comprehensive policy in place to support staff of the process to follow if patients wanted to complain, leave suggestions or provide positive feedback. Comments received were discussed within the practice team to share learning and improve patient satisfaction. The practice had implemented a process to review how patients shared feedback. A member of staff had been given the role of Complaints First Responder to acknowledge the complaint and 	

provide information to the patient on the actions that would be taken. A patient feedback form had been created for patients to use to share information.

Feedback from Patient Participation Group.

Feedback

We spoke with a member of the patient participation group who told us the practice staff were supportive and caring. The impact of the COVID-19 pandemic had caused the group to decline, however the practice were actively encouraging patients to join.

We were told regular communication was provided on any changes that were planned and the practice listened to ideas and suggestions.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• Systems and processes were in place to manage the risks and issues identified through risk assessments, incidents and significant events. We found the practice had clear, concise information available to all staff to ensure learning was shared effectively.• Clinical meetings were being held each month for all clinical staff to share information and through learning.• Time was allocated for staff to complete mandatory training.• Regular audits were in place to monitor quality improvement and implement improvements to ensure patients received the appropriate care and treatment.	

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 SICBL 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 SICBL 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.