

## Inspection Evidence Table

Dr Irlam and Partners

(1-550732343)

Inspection Date: 13 December 2023

Date of data download: 10/11/2023

## Overall rating: Requires Improvement

### • Context

- Dr Irlam and Partners, (known locally as Central Surgery), is located in purpose built facilities in Southend on Sea, Essex.
- The provider is registered with CQC to deliver the Regulated Activities: diagnostic and screening procedures, maternity and midwifery services, family planning, treatment of disease, disorder or injury and surgical procedures.
- The practice is situated within the Mid and South Essex Integrated Care System (ICS) and delivers General Medical Services (GMS) to a patient population of about 8,000. This is part of a contract held with NHS England.
- The practice is part of the Southend East Primary Care Network which is a network of 5 local GP practices.
- Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the fourth lowest decile (4 of 10). The lower the decile, the more deprived the practice population is relative to others.
- According to the latest available data, the ethnic make-up of the practice area is 5.5% Asian, 87% White, 3.2% Black, 3.2% Mixed, and 1.2% Other.
- The age distribution of the practice population closely mirrors the local and national averages.

**Safe**

**Rating: Requires Improvement**

We have rated Safe as Requires Improvement because:

- There was a documented approach to the management of test results and this was generally managed in a timely manner. However, we saw some test results from the 3 months preceding the inspection which were still in the documents inbox awaiting processing. Staff told us that they had been reviewed and required no further action and were awaiting filing.
- We used clinical searches to review some patients' records to monitor patient outcomes. We found that most patients were receiving effective treatment and medicine reviews however, some patients required further monitoring action to meet best practice guidance for the treatment being provided. Where action was required, this took place during the inspection.
- There was a system in place to respond to safety alerts from a variety of sources, including The Medicines and Healthcare products Regulatory Agency, (MHRA), and Central Alerting System, (CAS). However, this system was not always effective.

### 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
<ul style="list-style-type: none"> <li>• The discussions between the practice and other health and social care professionals were carried out via Teams calls on an 'as and when' required basis. All professionals had access to the same clinical system which enabled them to track and monitor any tasks assigned to a particular individual.</li> </ul>	

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.	Y
Date of last assessment:	20 September 2023
There was a fire procedure.	Y
Date of fire risk assessment:	20 September 2023
Actions from fire risk assessment were identified and completed.	N/A

### **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.	Y
Date of last infection prevention and control audit:	5 December 2023
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
<ul style="list-style-type: none"> <li>An infection prevention and control audit had been carried out on 5 December 2023. Following this audit, some concerns had been identified and staff told us that this was work in progress.</li> </ul>	

### **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
<ul style="list-style-type: none"> <li>A number of the non-clinical staff worked part-time hours and they told us that they were happy to provide cover for absent staff when necessary.</li> </ul>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	P
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<ul style="list-style-type: none"> <li>There was a documented approach to the management of test results and this was generally managed in a timely manner. However, we saw some test results from the 3 months preceding the inspection which were still in the documents inbox awaiting processing. Staff told us that they had been reviewed and required no further action and were awaiting filing.</li> </ul>	

## Appropriate and safe use of medicines

**The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, these were not always effective.**

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) (01/07/2022 to 30/06/2023) (NHSBSA)	0.79	1.04	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). (01/07/2022 to 30/06/2023) (NHSBSA)	7.5%	9.1%	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 Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	6.69	6.28	5.24	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	80.2‰	135.6‰	129.5‰	No statistical variation

Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.61	1.01	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	6.1‰	9.5‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
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
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	P
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
<ul style="list-style-type: none"> <li>The practice was aware of the data for the average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and</li> </ul>	

Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023). The practice had worked proactively to reduce the number of prescriptions and the most recent verified data showed that there had been an improvement for the period June 2023 – September 2023.

- We used clinical searches to review some patients' records to monitor patient outcomes. We found that most patients were receiving effective treatment and medicine reviews however, some patients required further monitoring action to meet best practice guidance for the treatment being provided. Where action was required, this took place during the inspection.
- During the inspection all the patients identified as requiring further monitoring had been reviewed and a revision to the practice procedure was put in place. We were told this revised procedure would be part of the monthly review process for assurance in the future.
- We identified 29 patients who were prescribed Methotrexate and of these we identified 18 patients who had potentially not received the required monitoring. We looked at 5 of these patient records in more detail and found that 1 of these patients was overdue their monitoring.
- We identified 27 patients who were prescribed Warfarin and of these we identified 15 patients who had potentially not received the required monitoring. We looked at 5 of these patient records in more detail and found that 1 patient was overdue their monitoring.
- We identified 136 patients who had a potential missed diagnosis of chronic kidney disease, stages 3-5. We looked at 5 of these patient records in more detail and found that all 5 patients had a missed diagnosis or they hadn't been coded correctly on the clinical system to ensure that they received the correct care and treatment.
- We identified 488 patients who had received a medication review in the previous 3 months. We looked at 5 of these patient records in more detail and found that all of the reviews were of an acceptable standard.
- We identified 107 patients who were prescribed gabapentinoids and of these we identified 19 who had potentially not received the required monitoring. We looked at 5 of these patient records in more detail and found that all 5 of these patients had not received the required monitoring.

## 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:	2
Number of events that required action:	2

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

Event	Specific action taken
A patient's self-taken blood pressure result was incorrectly recorded on the wrong patient record.	<ul style="list-style-type: none"> <li>An apology was given to both patients and their patient records were amended.</li> <li>This was discussed at a team meeting and a procedure was implemented to ensure that at least 2 identity checks were made to minimise the risk of this situation recurring.</li> </ul>
A patient had a repeat medicine cancelled, but the pharmacy had not been notified. The patient notified the practice.	<ul style="list-style-type: none"> <li>The reason for the error was identified and an apology was given to the patient.</li> <li>The pharmacy was instructed to stop dispensing the medicine with immediate effect.</li> <li>The staff team who had not contacted the pharmacy to cancel the medicine met to discuss the situation.</li> <li>A procedure was put in place with a safety net for the processing of all prescription medicines which were cancelled by a GP.</li> </ul>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P
Staff understood how to deal with alerts.	P
<ul style="list-style-type: none"> <li>There was a system in place to respond to safety alerts from a variety of sources, including The Medicines and Healthcare products Regulatory Agency, (MHRA), and Central Alerting System, (CAS). However, this system was not always effective.</li> <li>During the remote clinical searches, we looked at a safety alert issued by MHRA which concerned patients who were prescribed an aldosterone antagonist + ACEI/ARB. Our searches showed that 32 patients were prescribed this combination of medicines. Of these, we identified 11 patients who had potentially not received the required monitoring. We looked at 5 of these patient records in more detail and found that 4 of them had not received the monitoring needed.</li> <li>During the inspection, the practice contacted all 11 patients who had possibly not had the required monitoring and issued a blood test form. This was in addition to the new procedure for prescribing repeat medicines.</li> </ul>	

**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>• Those identified received a full assessment of their physical, mental and social needs.</li> <li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</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.</li> <li>• All patients with a learning disability were offered an annual health check.</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.</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 disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

During the remote clinical searches:

- We identified 847 patients who had been diagnosed with asthma. We found that 33 of this group of patients had been prescribed 2 or more courses of rescue steroids in the previous 12 months. We looked at 5 of these patient records in more detail and found that 3 of these patients had not been given an adequate assessment at the time of prescribing the medicine or consistently followed up within 1 week of their steroids. During the inspection the practice had taken action to rectify this and refresher training for clinicians was delivered. NICE guidelines relating to acute exacerbation of asthma were implemented.
- We identified 24 patients who were diagnosed with chronic kidney disease (CKD) stage 4 or 5. We found that 6 of these patients had potentially not received the correct monitoring. We looked at 5 of these patient records in more detail and found that 2 patients were overdue monitoring and their record had not been updated to include their diagnosis. One patient record had not been updated to reflect their diagnosis, but monitoring was up to date.
- We identified 282 patients who were diagnosed with hypothyroidism. We found that 38 of these patients had potentially not received the correct monitoring. We looked at 5 of these patient records in more detail and found that all 5 were overdue monitoring and/or a medication review. During the inspection, the practice contacted all patients to attend for a medication review and a blood test. Patients who were overdue monitoring had their amount of medicine reduced until the tests were completed and analysed. A safety net was put in place to ensure patients who were overdue monitoring were booked an appointment with a GP or clinical pharmacist.
- We identified 67 patients with diabetic retinopathy who's latest HbA1c was >74mmol/l. We looked at 5 of these patient records in detail and found that all of these patients had received the correct monitoring for their condition.
- 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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- 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)	79	85	92.9%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	84	90	93.3%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	84	90	93.3%	Met 90% minimum
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)	84	90	93.3%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	77	88	87.5%	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
<ul style="list-style-type: none"> <li>The practice was aware that their performance for 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) was slightly lower than the required 90% minimum. However, they had been proactive in trying to improve this and provided unverified recent data that showed uptake of the vaccination had exceeded the 90% minimum.</li> </ul>

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)	61.8%	N/A	62.3%	N/A

Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	65.9%	N/A	70.3%	N/A
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)	47.6%	56.9%	54.9%	No statistical variation
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). (6/30/2023 to 6/30/2023) (UKHSA)	68.3%	N/A	80.0%	Below 70% uptake

#### Any additional evidence or comments

- The practice was aware that their performance for 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). (6/30/2023 to 6/30/2023) was slightly below the required 70% minimum. However, the practice had been proactive in addressing this and performance had been on an upward trend since March 2023 and work was continuing to increase uptake.

#### 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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> <li>The practice had carried out an audit on all patients who were prescribed zopiclone with a view to a reduction in the overall level of prescribing. All patients who were prescribed the medication were reviewed and invited to attend a discussion with a GP or pharmacist to review their prescription. As a result some patients agreed to a reduction plan or other actions. Following this audit and subsequent actions, the level of prescribing zopiclone by the practice had reduced significantly. There was a plan to conduct a second stage audit in the months following the inspection.</li> <li>The practice had carried out an audit of GLP-1 mimetics prescribing in adults with type 2 diabetes. The object of the audit was to ensure that prescribing was in line with NICE guidance. At the time of inspection, the results of this audit were being analysed and a second audit had been scheduled, following the completion of identified actions.</li> </ul>	

**Effective staffing**

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

**Coordinating care and treatment**

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

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

**Helping patients to live healthier lives**

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y

Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y

### Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Y

## 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
On site interviews	Patients we met on site spoke positively about the clinical and non-clinical staff, using words such as: 'caring', helpful' and 'understanding'.

## 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)	79.1%	82.5%	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 professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)	72.8%	81.6%	83.8%	No statistical variation
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)	93.6%	92.9%	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)	62.9%	68.5%	71.3%	No statistical variation

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

### Any additional evidence

- The practice received patient feedback from the friends and family test, which consistently showed positive results.
- Patients were sent a text message after each appointment, asking for feedback on their experience. This was analysed and if any feedback required a response, the patient was contacted. In addition the responses were collated and discussed to identify any trends so that appropriate improvements could be made.
- At the time of inspection, there were 3 registrars in training at the practice. They requested patient feedback after each consultation which was discussed with the GPs and used for their continuing learning.

### Involvement in decisions about care and treatment

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

	Y/N/Partial
--	-------------

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

### 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 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)	86.4%	89.6%	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.	362 carers had been identified which was approximately 4.5% of the patient list.
How the practice supported carers (including young carers).	The practice was playing an active role in the primary care network (PCN) campaign to identify and support carers using a variety of methods.
How the practice supported recently bereaved patients.	The duty GP called the next of kin when the practice was informed that a patient had passed away. The next of kin was provided with information on next steps and where they could access support locally. They were also offered an appointment with the social prescriber at the practice who had knowledge of what support and advice was available in the local area.

### 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

We have rated Responsive as Requires Improvement because:

- We recognise the pressure that practices are currently working under and the efforts staff are making to maintain levels of access for their patients. At the same time, our strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. Although we saw the practice was attempting to improve access, this was not yet reflected in the GP patient survey data or other sources of patient feedback. Therefore, the rating is requires improvement, as ratings depend on evidence of impact and must reflect the lived experience that people were reporting at the time of inspection.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am– 6.30pm
Tuesday	8am– 6.30pm
Wednesday	8am– 6.30pm
Thursday	8am– 6.30pm
Friday	8am– 6.30pm
Appointments available:	
Monday	8.30am – 11.30am 2pm - 4pm 4.15pm – 6.15pm

Tuesday	8.30am – 11.30am 2pm - 4pm 4.15pm – 6.15pm
Wednesday	8.30am – 11.30am 2pm - 4pm 4.15pm – 6.15pm
Thursday	8.30am – 11.30am 2pm - 4pm 4.15pm – 6.15pm
Friday	8.30am – 11.30am 2pm - 4pm 4.15pm – 6.15pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Pre-bookable evening and weekend appointments were also available to all patients at additional locations within the area.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

#### Access to the service

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

	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.	P
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.	P
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

## 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)	30.3%	N/A	49.6%	No statistical variation
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)	40.2%	49.9%	54.4%	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 (01/01/2023 to 30/04/2023)	31.9%	50.9%	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)	55.8%	70.0%	72.0%	Tending towards variation (negative)

### Any additional evidence or comments

- Performance for 2 of the above indicators relating to access had been on a downward trend since 2020 and the remaining 2 indicators had been on a downward performance trend since 2021.
- Some recent action had been taken to address the issue of access. Phone lines had been increased to 4, but with 2 receptionists on duty at any time, this was not as effective as required to reduce waiting times for calls to be answered.
- Although the phone system was digital, it was not cloud based and this made monitoring of the call queue difficult. The practice had worked with the ICB to agree funding arrangements to install a new telephony system with a plan to improve waiting times for patients. This was due to take place in January 2024.

## Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	5
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2

Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
--	---

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient unhappy about a backdated sickness certificate procedure and the possible implications of this.	The patient was taken to a private room to discuss the situation and the procedure the surgery had to follow. A written response was also sent to the patient. The complaint was discussed at a practice meeting and it was agreed to ask the patient if they would like to see a social prescriber to assist with any problems the lack of a backdated sickness certificate may cause them.
Patient unhappy about how a request for medication was dealt with by reception staff.	The patient was contacted by telephone and offered an apology which they accepted. The patient's medication was reviewed and an amendment was made to avoid a similar situation occurring in the future. This was discussed at a team meeting and all reception staff were advised to contact a clinician if a similar situation occurred with another patient.

## 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

- The partnership at the practice was long-standing and stable and there were no plans in place to change this in the near future.

### Vision and strategy

**The practice had a clear vision and credible strategy to provide high quality sustainable care.**

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

### Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<ul style="list-style-type: none"> <li>• Staff we spoke with during the inspection told us that they felt able to raise any concerns or to report any mistakes without fear.</li> <li>• Staff told us that clinical and non-clinical leaders regularly considered their well-being. Leaders had provided a session for all staff led by a local mental health organisation, focusing on their overall well-being. Staff were provided details if any follow-up contact was needed.</li> <li>• Leaders also provided the opportunity for staff to attend organised social gatherings outside of working hours and also regular lunchtime treats.</li> </ul>	

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

Source	Feedback
Staff Interviews	Staff we spoke with told us: <ul style="list-style-type: none"> <li>• They felt supported</li> </ul>

	<ul style="list-style-type: none"> <li>• Leaders were knowledgeable and approachable</li> <li>• They were encouraged to develop their skills if they wanted to</li> <li>• Their well-being was considered by leaders</li> </ul>
--	---

### Governance arrangements

**There were not always 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.	P
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
<ul style="list-style-type: none"> <li>• There were systems to maintain and improve the quality of patient care and the service delivery which were led by senior members of staff. However, we found the governance arrangements to ensure patients' care was reviewed and monitored and patient access to services were not always effective. This had been rectified during the inspection.</li> </ul>	

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	P
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
<ul style="list-style-type: none"> <li>• We found the governance arrangements sometimes resulted in a lack of oversight in risk management processes that caused some patients not to receive the required reviews and monitoring. Our clinical searches resulted in some issues being raised in relation to the way patients prescribed certain high-risk medicines and those with long term conditions were monitored and reviewed. These issues were addressed during the inspection.</li> </ul>	

### Appropriate and accurate information

**There was a demonstrated commitment to using data and information proactively to drive and support decision making.**

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

## Governance and oversight of remote services

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



- The practice and the PPG worked well together.
- Clinicians were always willing to listen to suggestions and were open to new ideas.
- The PPG had been instrumental in some improvements in the practice including the provision of an information screen in the reception area.
- The PPG were consulted when there were proposed changes.
- The PPG had begun to work with the PCN PPG in the local area.
- The Chair of the PPG was involved in the wider local healthcare landscape and was able to share experiences and knowledge with the practice.

## 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

## Examples of continuous learning and improvement

- The practice was a training practice and at the time of inspection there were 3 registrars in training.
- Complaints and significant events were discussed and the learning was shared.
- There was a programme of audit and improvement in place.
- Staff were encouraged to attend training courses relevant to their role or professional development.

## 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 ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of 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 those aged 25 to 49, and within 5.5 years for those 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.