

Inspection Evidence Table

Dr Chitre & Dr Dasari's Surgery (1-8537574116)

Inspection Date: 10 and 11 July 2023

Date of data download: 12/06/2023

Overall rating: Requires improvement

We found that the processes and systems the provider had implemented to monitor the quality and safety of services were not always effective or fully embedded.

The practice is therefore rated requires improvement.

Safe

Rating: Requires improvement

We found that systems and processes for keeping people safe, for example infection prevention and control, risk assessments relating to the premises and medicines management were not always effective.

The practice is therefore rated requires improvement for providing safe services.

Safety systems and processes
Systems, practices and processes to keep people safe and safeguarded from abuse required improvement.

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

professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The provider had produced a safeguarding policy, we saw that staff were able to easily access it. The policy had been updated yearly however did not include updates to training requirements for non-clinical staff. During the inspection we found that clinical staff had received appropriate training for safeguarding adults and children. However, non-clinical staff had not received the correct level of training. Non-clinical staff we spoke with were able to tell us who they would report concerns to, and what types of concerns they would report. The safeguarding policy did not make reference to female genital mutilation (FGM). Staff told us they had completed training on FGM and we saw there was information available to them in clinical rooms to help support them if they had concerns. The provider sent us evidence to show, following the inspection, they had reviewed and improved their safeguarding policy and non-clinical staff had completed the required level of training. The practice used alerts on their clinical patient record system to alert staff about any safeguarding concerns. However, we found that staff were not placing alerts on all family or household members to alert staff of possible safeguarding concerns with another patient in that household. The provider told us, following the inspection they had acted to place alerts on all relevant patient's records. The practice held safeguarding registers, which were reviewed by the safeguarding lead. We saw that actions following a safeguarding meeting were added to the patients' records. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff files we viewed were well organised and contained relevant information.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
<p>Date of last assessment:</p> <p>18 August 2022 at main practice</p> <p>4 August 2022 at branch practice</p>	
There was a fire procedure.	Yes

Date of fire risk assessment: 18 August 2022 at main practice 4 August 2022 at branch	
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The provider demonstrated that appropriate risk assessments related to the premises had been carried out, however, actions following risk assessments had not been fully completed. • We saw that while some actions had been completed following Health and safety, premises, legionella and fire risk assessments, other actions remained outstanding and there was not always a planned date for completion. • The provider did not own the premises and actions identified following risk assessments had been passed to the landlord for each property, for completion. • The provider told us they were in communication with the landlord for each property to get the remaining actions resolved. • The provider sent us evidence, which showed, following the inspection, they had risk assessed the actions that were outstanding and they told us they would be meeting with the landlords for each premises to discuss them further. • The provider had systems in place to monitor medical equipment and assess its suitability. For example, the provider had arranged for equipment to be PAT (portable appliance test) tested and calibrated to ensure it was safe to use. 	

Infection prevention and control

Systems and processes to manage infection, prevention and control (IPC) required improvement.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: Main Practice – June 2023 Branch Practice – September 2022	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The last infection prevention and control (IPC) audits carried out in September 2022 at the branch site and June 2023 at the main practice site showed improvements at both sites from the previous IPC audit scores. Previous achievement was 86% October 2022 at the main practice, this increased to 95%. At the branch site the result achieved was 91% in July 2022 at the repeated audit in September 2022 a score of 99% was achieved. 	

- We found that sharps bins were signed and dated and stored appropriately in clinic rooms.
- We found that the provider had arrangements in place for the collection of clinical waste. However, clinical waste awaiting collection at the main practice was not stored appropriately. Although it was stored away from patient view/access, it was not being stored in a designated clinical waste bin. Staff told us they had recently changed the company who collected the waste and new storage bins had not been provided by the company.
- Staff took immediate action to order new clinical waste bins.
- During the inspection at the main practice we identified other infection prevention and control (IPC) issues that had not been identified on the practice's IPC audit. These included: the sink in the clinical room was not suitable and re-decoration was required in one of the clinical rooms underneath the sink.
- There were areas inside and outside at the main practice that required decoration and maintenance. The management team told us these had been raised with the landlord of the premises. However, there were no immediate plans to decorate the outside of the building. Staff told us the inside of the building was in the process of being decorated.
- The provider told us, following the inspection, they had taken action to order a new sink for the clinical room.

Risks to patients

There were 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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Partial
Explanation of any answers and additional evidence: The provider had employed additional staff to support safer medicines management processes. However, staff told us due to increasing demand for patient appointments, clinicians were being re-deployed to provide appointments. This indicated there were not always enough staff to provide appointments and deliver services safely.	

Information to deliver safe care and treatment

Staff did not always have 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	No
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none">• We found the practice was up to date in processing blood test results and there was no backlog in reviewing correspondence from other services.• A review of patient records in relation to the clinical searches identified that care records were not always managed in a way to protect patients. For example, we found that medicine reviews were not always documented to demonstrate what had been reviewed, what action was taken, and if the patient had been involved.• The provider told us a additional clinical staff had been employed to help support the practice with medicine reviews and they were working through the backlog.• Staff told us medicine reviews were being carried out, however there was not always detail within the patient's record to evidence this.• We found that a clear reason for prescribing medicine was not always documented in the patient's record.• We found that patient's records were not always coded correctly. For example, not all records we viewed had been coded to indicate a DNACPR decision had been made.• Following the inspection, we discussed the above concerns related to record keeping with the provider. They told us they had taken immediate action to code records correctly with DNACPR information and there was already a plan in place to work through a backlog of medicine reviews, however they would be employing additional clinical staff to support them further.	

Appropriate and safe use of medicines

The systems for the appropriate and safe use of medicines, including medicines optimisation required improvement.

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.98	0.92	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) (NHSBSA)	2.1%	5.6%	7.8%	Significant variation (positive)
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 (01/10/2022 to 31/03/2023) (NHSBSA)	5.58	5.22	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	145.2‰	142.3‰	129.8‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.97	0.63	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	12.1‰	9.0‰	6.8‰	Tending towards variation (negative)

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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	No
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
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	No

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).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> • We found the system in place to store blank prescriptions and monitor their use was not effective. The management team took immediate action to improve the system so that blank prescription stationery was kept secure and its use could be more effectively monitored. • The provider could not evidence they had processes in place for the safe handling of requests for repeat medicines. From record reviews, we found that patients were being issued repeat prescriptions without an assessment of their monitoring or ongoing needs. • The provider could not evidence that effective medicines reviews for patients on repeat medicines had taken place. Staff told us that medicine reviews had been conducted, however they could not evidence documentation relating to the outcomes from the review, if required monitoring or changes to treatment had been addressed, during a comprehensive review. • The provider told us, following the inspection, they had identified which patients needed monitoring and/or follow up and they were working their way through the patient list. They also told us they would review their process for how repeat prescriptions were issued. • The provider informed us they had employed additional clinical staff who were working through a backlog of patients who required effective medicine reviews. • We found where shared care agreements were in place with specialist services, the provider could not always evidence they had carried out relevant monitoring in line with guidelines to ensure that medicines were prescribed safely. 	

- The clinical searches identified that while there were systems in place to monitor most patients' health in relation to the use of high risk medicines with appropriate monitoring and clinical review prior to prescribing, this was not consistent for all high risk medicines. For example:
- The clinical searches identified a total of 4 patients taking a medicine which may be used to treat mood disorders. Of these patients, we identified all 4 patients as appearing to be overdue appropriate monitoring. We sampled all 4 of these records and found that there were problems with the care for all 4 patients. The provider could not demonstrate they had an effective process in place to monitor this group of patients in line with national guidance. We found that these patients had received some monitoring before prescriptions were issued however, not all parameters were monitored. in line with guidance. We saw evidence of the practice attempts to contact the patients in order to arrange for monitoring to be carried out and the provider told us they had processes in place to reduce the quantity of medicines prescribed to encourage patients to attend for required monitoring.
- The clinical searches and record reviews identified there was some use of alerts on patient records to remind staff what monitoring was required before prescribing high risk medicines, however this was not consistent.
- The provider told us, following the inspection, they had immediately contacted all relevant patients for high risk medicines monitoring.
- Staff told us of the arrangements in place to provide clinical supervision to non-medical prescribers. They told us a GP was always on site and were available if the non-medical prescriber needed support. There were opportunities to discuss complex patients to review decisions made and although there was evidence that formal audit of records took place, this process was not consistently carried out.

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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	7
Number of events that required action:	7
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • All staff we spoke with were aware of how to report incidents and could give us examples of incidents that had occurred and subsequent learning. 	

- We saw from meeting minutes that staff had opportunities to learn from safeguarding and safety incidents at staff meetings.
- The management team responded appropriately to concerns raised with them during the inspection process, to improve systems and processes.

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

Event	Specific action taken
Fridge failure	<ul style="list-style-type: none"> • Appropriate action was taken at the time to ensure staff did not use the vaccines. • Staff contacted the relevant organisation to seek advice. • Learning was shared with all staff to ensure the incident did not happen again.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We saw from meeting minutes that safety alerts were discussed with staff during staff meetings and alerts were placed on patient's records to remind staff where necessary about required monitoring/action needed. • Our clinical searches indicated that while most safety alerts had been responded to appropriately, the provider was unable to demonstrate there was oversight of all alerts and that all relevant safety alerts had been responded to. • For example, we looked at the records of 5 patients prescribed a combination of medicines that required regular monitoring. We found that although alerts had been placed on the 5 records, to remind clinicians about the required monitoring, none of the patients had been followed up in line with national guidance. • The provider took immediate action, following the inspection to contact the relevant patients and invite them for monitoring. 	

Effective

Rating: Requires improvement

We found that the provider could not demonstrate that patients always received the required monitoring and follow up to provide effective care and treatment.

The practice is therefore rated requires improvement for providing effective services.

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

Effective needs assessment, care and treatment

Patients’ needs were not always assessed, and care and treatment was not always 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.	Yes
Patients’ immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients’ treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients’ needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Our clinical searches and record reviews indicated that patient’s ongoing needs and medicine reviews were not consistently monitored and documented to demonstrate that patients were always fully assessed in line with national guidance.	

Effective care for the practice population

Findings

- Our review of clinical records identified that patients did not always receive a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check. Records we reviewed, showed a thorough assessment and review had been carried out. However, the provider could not demonstrate that all patients had care plans that had been discussed and agreed with patients and or their carers.
- 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 did not always assess and monitor the physical health of people with mental illness, severe mental illness, and personality disorder in line with guidelines. Staff told us this group of patients were more difficult to contact and did not always attend for their appointments. Clinical searches indicated patients prescribed mood stabilising medicines were not monitored and followed up in line with guidelines.
- Patients with poor mental health, including dementia, were referred to appropriate services. However, we found the provider could not demonstrate that care plans for people living with dementia were always completed with the patient and/or their carer.
- The practice supported patients living in a local care home. Staff told us they carried out regular ward rounds and attended the care home to review patients face to face as required. Care home staff we spoke with confirmed they could contact the practice for support as needed and they had a good relationship with the practice.

Management of people with long term conditions

Findings

- We found that most patients with long term conditions such as asthma, diabetes and hypothyroidism were monitored and followed up in line with guidelines and there was evidence of completed care plans.
- However, our clinical review of patient's records identified areas of concern. For example, we found 22 patients with blood tests indicating they may have undiagnosed diabetes which had not been identified or recorded in their records. The provider could not demonstrate these patients were reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm.
- We discussed these patients with the provider, they told us they were aware of these patients. It was explained that this was a small group of patients who wanted to try to improve their health by means other than medication for example, lifestyle changes. Following the inspection, the provider had sought guidance from a diabetes specialist and told us going forwards they would be coding these patients correctly and arranging follow up in line with guidance.
- We found that while asthma patients had received effective annual reviews they were not being followed up after an acute exacerbation of asthma in line with national guidance to ensure they received appropriate care. The provider told us, following the inspection, they had met with practice staff to

discuss how they would ensure these reviews were carried out in the future.

- Patients with long-term conditions were offered a comprehensive 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)	69	75	92.0%	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)	68	70	97.1%	Met 95% WHO based target
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)	68	70	97.1%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	68	70	97.1%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	63	76	82.9%	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 processes in place to contact parents or carers to remind them about appointments and to follow up patients who had not attended for their appointment.
- Staff had met to discuss where they were not meeting targets and how they could improve uptake.
- When parents declined immunisations for their child, they were asked to have a consultation with staff

before signing a disclaimer so that staff could give them more information on the importance of having the immunisation.

- Staff still contacted parents even if they had previously declined, to encourage them to attend for immunisations.

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)	60.9%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	57.2%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (12/31/2022 to 12/31/2022) (UKHSA)	60.2%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	50.0%	48.3%	54.9%	No statistical variation

Any additional evidence or comments

- Staff told us they had met with the management team to discuss uptake of cervical cancer screening and how they could improve uptake.
- Non-clinical staff contacted patients to book an appointment and then reminded patients to attend their appointment.
- Staff told us they had arranged additional clinics to improve uptake and they offered opportunistic appointments.

Monitoring care and treatment

The provider had some systems in place to review the effectiveness and appropriateness of the care provided.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Partial
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two	

years:

- We saw the practice had carried out an audit to review those patients diagnosed with cancer, to see if they had been referred appropriately. Staff told us the audit had led to improvements in clinical care, for example, improved safety netting.
- We saw evidence of medicines management audits, including high risk medicines that required regular monitoring. The audit showed between October and December 2022 14 of 16 patients (88%) on a high risk medicine used to reduce inflammation (swelling) had received the required monitoring to ensure safer prescribing. Following the audit, the practice took action to contact the remaining 2 patients. At the time of the inspection, the practice had not yet repeated the audit.
- We found the practice had systems in place to monitor information coming into the practice, notifying them about unplanned admissions and readmissions. Staff told us what action they took if patients including children were repeatedly attending hospital. However, the provider could not demonstrate that patients who had been treated for an acute exacerbation for asthma were always followed up in line with guidelines. Following the inspection, the provider told us they would be working with clinical staff to improve this process.

Any additional evidence or comments

We saw evidence of non-clinical audits for example to monitor cleaning standards.

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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • We saw evidence of formal clinical supervision for nursing staff. • The provider told us of the arrangements in place to supervise non-medical prescribers. 	

- Staff had completed required training and specialist training required for their role.
- The provider has systems in place to monitor that staff were compliant with required training.

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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: Staff told us they worked with specialist services for example respiratory and diabetes services to support more complex patients.	

Helping patients to live healthier lives

Staff were not 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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Partial
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: From our review of clinical records, in particular care plans, the provider could not demonstrate that patients were always involved in their care or that care plans had been discussed and agreed with patients and/or their carer where necessary.	

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Yes
Explanation of any answers and additional evidence, <ul style="list-style-type: none">We found that staff were making and recording DNACPR decisions appropriately, however, they were not always coding the record correctly. This meant that decisions may not be monitored or shared with others.The provider told us, following the inspection, they took immediate action to review and update relevant records to code them correctly.	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Interactions we observed between staff and patients, showed that staff listened to patients and treated them with kindness.	

Patient feedback	
Source	Feedback
NHS UK	There were no recent reviews posted on the website.

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 (01/01/2022 to 30/04/2022)	67.7%	79.0%	84.7%	Variation (negative)
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 (01/01/2022 to 30/04/2022)	63.3%	76.9%	83.5%	Variation (negative)
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 (01/01/2022 to 30/04/2022)	80.2%	89.5%	93.1%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	51.2%	62.3%	72.4%	Tending towards variation (negative)

Any additional evidence or comments

- Staff had met to discuss the results of the 2022 patient GP survey and had formed an action plan. They were aware that difficulties in accessing appointments was negatively impacting patients' overall experience of the practice.
- Staff told us they had increased the number and range of appointments available. Patients also had access to additional appointments provided through the primary care network on weekends.
- Staff also told us some patients attended for multiple problems and became frustrated when they were asked to book another appointment if the clinician was not able to deal with multiple issues at the one consultation. Practice staff were required to try to educate patients on this and other challenges they face for example, chasing up hospital referrals.
- Non-clinical staff had been provided with in-house training to improve customer service skills.
- Clinical staff told us that appointments had been reviewed to ensure patients had enough time to ask questions and to discuss care management plans.
- During this inspection, the results of the 2023 patient GP survey were published. We saw that patient satisfaction had remained the same when compared with the previous years' survey.

Y/N

The practice carries out its own patient survey/patient feedback exercises.	Yes
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Any additional evidence

- To monitor their action plan and patient experience, the practice management team monitored responses to the friends and family test and had carried out an in house survey in June 2023. All registered patients were asked to complete a survey, which they received as a text message. The practice received 472 responses. The results were positive and showed that patients were satisfied in relation to how caring the service was.
- We saw evidence of the friends and family test results for June 2023 and found where patients had left negative comments, these were related to appointment availability. Positive comments included that staff were understanding and patients had had a positive experience.

Involvement in decisions about care and treatment

There was some evidence that 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.	Partial
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Information in multiple languages was available and staff told us they had access to interpreters or staff who spoke multiple languages. The practice had a hearing loop in place to support patients with hearing difficulties. Practice staff could not demonstrate that patients and/or their carers were always supported to understand and encouraged to be involved in decisions about their care, treatment and condition. 	

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 (01/01/2022 to 30/04/2022)	78.3%	85.2%	89.9%	Tending towards variation (negative)
Any additional evidence or comments				
<ul style="list-style-type: none"> The practice had met to discuss the results of the 2022 survey and formed an action plan. The in house survey showed that patient experience had improved and the 2023 national GP survey results showed patient satisfaction with how involved they felt had improved to 82%. 				

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

Carers	Narrative	
Percentage and number of carers identified.	The practice had identified 58 patients of their patient list as carers. This was approximately 1% of their patient list.	
How the practice supported carers (including young carers).	The practice offered carers health checks and flu immunisations and sign posted carers to support groups.	
How the practice supported recently bereaved patients.	The practice sent recently bereaved patients a bereavement card and offered a GP appointment and/or referral to counselling services.	
Information about support groups was available on the practice website.		Yes
Explanation of any answers and additional evidence:		

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.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence:	

Responsive

Rating: Requires improvement

We found, despite efforts taken to improve access, the provider could not fully demonstrate that patient satisfaction had significantly improved. The practice is therefore rated requires improvement for providing responsive services.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Partial
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The provider was aware that the patient population for both practices were different and had assessed the needs of each patient population. The provider had made positive attempts to organise services so that patient needs could be met. There was ongoing actions for both sites to improve access in and out of the building. We saw that some actions had a completion date, for example, for automatic doors to be fitted to the main practice's entrance. Other identified actions required to improve access had been passed to the landlord who had not provided a date for when this work would be completed. We found that staff could access interpreters and there were staff who spoke multiple languages. The practice had a hearing loop and disabled access toilets. 	

Practice Opening Times	
Main practice opening times	
Day	Time
Monday	9am - 6.30pm
Tuesday	9am - 6pm
Wednesday	9am - 12pm
Thursday	8am - 6.30pm
Friday	9am - 6pm
Branch practice opening hours	
Monday	8am – 8pm
Tuesday	8am - 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am - 3pm
Friday	8am – 6.30pm

Weekend opening times	As part of the Primary care network (PCN) arrangements, patients can book appointments on a weekend between 9am and 12 midday on a Saturday and Sunday.
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Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients organised by the local pharmacy.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 8pm on a Monday at the branch practice for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child under 5 were offered a same day appointment when necessary.
- The branch practice was open until 8pm on a Monday. Pre-bookable appointments were also available to all patients at additional locations on Saturdays and Sundays as part of arrangements through the PCN.
- 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 always not 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.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Explanation of any answers and additional evidence:	

- The provider was aware that access to phone lines and appointments was an area for improvement and was taking action to address this.
- The practice management team monitored live call data and told us that telephone access had improved.
- To free up telephone lines and improve access the practice had increased the use of text messages to communicate with patients.
- The management team had identified that staff were inappropriately using phone lines to communicate internally and had advised staff of alternative methods of communicating with staff in the practice, to help improve access.
- To improve appointment access the practice had increased the number of appointments available each week with a GP and had increased the range of appointments. For example, a clinical pharmacist had been employed to focus on medication reviews and minor illnesses. Patients had access to a musculoskeletal (MSK) physiotherapist once a week, a social prescriber and a mental health care coordinator.
- The practice management team told us that complaints relating to access had reduced after they had taken action to increase appointment availability.

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 (01/01/2022 to 30/04/2022)	39.9%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	36.4%	46.1%	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)	45.0%	48.6%	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)	48.6%	64.8%	71.9%	Variation (negative)

Any additional evidence or comments

- The practice had met as a team following the 2022 national GP patient survey to discuss how they would try to improve access.
- They monitored live call data and improvements in patient satisfaction by monitoring friends and family test results, complaints and had carried out an in house patient survey.
- The practice had received 475 responses to their in house survey in June 2023. The survey showed that while satisfaction with telephone access and appointment availability had improved, further actions were needed to continue to improve patient satisfaction further. From the results, we saw that approximately 50% of people who completed the survey found it hard to access the practice or were satisfied with their appointment time.
- During this inspection, the results of the 2023 national GP patient survey were published. The results showed that patient experience in making an appointment and telephone access had improved slightly, with the largest improvement seen in the number of patients satisfied with the appointment they were given. This had improved to 66% from 48.6% in 2022.

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were no recent reviews posted on the NHS website.

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.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
A complaint about the appointment process.	<ul style="list-style-type: none"> • The complaint was investigated and upheld. • Relevant staff received training. • The practice apologised and responded appropriately to the patient involved.

Well-led

Rating: Requires improvement

The provider could not always demonstrate there was effective oversight of governance processes or that systems were effective in ensuring that services were safe and of a high quality.

The practice is therefore rated requires improvement for providing well-led services.

Leadership capacity and capability

Leaders could not fully demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider was aware of the challenges they faced and they had tried to identify the actions required to address these. For example, they were aware that they needed to improve their systems to monitor patients on high risk medicines and carry out effective medicine reviews and had employed more clinical staff. However, due to an increased demand for appointments the additional clinical staff were being deployed to provide more appointments rather than being allowed to focus on the monitoring and medicine reviews.• Relevant risk assessments for the premises had been carried out and identified issues with the building had been passed onto the landlord for completion. From meeting minutes, we saw that management discussed outstanding actions with staff. The provider had followed up the actions with the landlord, however, could not demonstrate how they were mitigating the risks until the actions were complete. The provider sent us evidence to show, following the inspection, they had risk assessed the outstanding actions and told us they had plans to meet with the landlords again to discuss the actions.• Staff told us that whilst leaders were approachable, their concerns about quality or ideas for improvement were not always listened to.• The provider shared with us their plans for the practice and partnership, however these were informal and in the early stages.	

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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider's mission was to deliver excellent care, keep to the standards and to provide an appropriate and rewarding experience for their patients whenever they needed support.• Staff we spoke with shared the provider's vision and understood their role in achieving it.• The provider had a strategy and business plan for improving the service further. Staff told us the plan was reviewed by the practice management team throughout the year.	

Culture

The practice had a culture which aspired to drive high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• All staff we spoke with were passionate about providing high quality services.• From meeting minutes we viewed, we saw that all staff met monthly to discuss a comprehensive agenda that included areas of risk and performance.	

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

Source	Feedback
Staff we spoke with	Staff felt supported by management. They reported good relationships between management and themselves. There were opportunities to learn and develop. However, they reported they did not always feel listened to when they were sharing concerns with the provider for example about workload or how systems could be improved.

Governance arrangements

The arrangements for governance were not fully clear or did not always operate effectively.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">We found there were some governance structures in place that worked well for example, oversight of recruitment and training, management of blood test results and correspondence from other services, and the management of incidents and complaints.However, not all governance structures were effective. For example, there was a policy in place for the security of blank prescriptions. We found the policy was not effective and there was no system in place to monitor if the policy was being followed.The provider could not demonstrate they had effective oversight of all medicines management processes to ensure safer prescribing.	

Managing risks, issues and performance

There were processes for managing risks, issues and performance. However, risks and issues were not always dealt with appropriately or quickly enough. The approach to service delivery and improvement was reactive and focused on short-term issues.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• We found there were processes in place to monitor and discuss performance with relevant staff.• We found there were processes in place to assess risk, however, processes were not always effective.• We found gaps in systems to manage and mitigate risk related to the quality of record keeping, IPC, the premises and medicines management.	

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• From meeting minutes we viewed, we saw that performance data was discussed with relevant staff to make further improvements to the service.	

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.	Yes

The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	N/A
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice was not providing online consultations at the time of the inspection. 	

Engagement with patients, the public, staff and external partners

The practice engaged with 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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Staff told us they had an active virtual Patient Participation Group (PPG) who they engaged with through email and newsletters. To keep patients engaged, the provider had decided to produce a newsletter for all patients that contained relevant information about the practice and links to further information. This was available for all patients, in particular those that did not access the practice website. We saw from staff meeting minutes that we viewed, service improvements and areas of concerns were discussed with all staff. Staff told us there were staff meetings and other opportunities for them to share their concerns or ideas for improvements with the provider, however they did not always feel their ideas were listened to. The practice staff collected and monitored patient satisfaction information to monitor if changes they had 	

already implemented were positively impacting patients and to identify where further improvements were needed.

- The provider worked with local practices within their PCN to provide a wider range of services.

Feedback from Patient Participation Group.

Feedback

The practice had a virtual Patient Participation Group (PPG). The practice told us they emailed the surgery newsletter to all the members in the group along with a questionnaire to enable the patients to comment on the newsletter. For example, how helpful the information was, did they have any topics they would like to have in the next newsletter and any other general suggestions or comments about the practice.

We saw evidence of completed questionnaires from members of the PPG. We saw that the practice discussed the responses they had received in staff meetings and developed an action plan to improve services further.

Any additional evidence

We saw from meeting minutes we viewed, the PPG and patient experience was a standing item on the agenda and staff discussed how to improve patient satisfaction in regards to appointment and telephone access.

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.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice demonstrated how they learnt from incidents and complaints to improve quality and safety. • The practice met regularly as a team to discuss issues and possible improvements to the service. • The practice had identified they needed to use an alternative method to seek patient feedback and had sent out the most recent in-house survey using text message. They told us they had a much better response from patients when compared with previous attempts. The survey showed that patient satisfaction was improving. • There were also attempts to engage with patients through a patient newsletter. • There was evidence of clinical audits and that clinicians learnt from audits to improve quality of care. • To improve access to appointments and the range of appointments available, patients had access to a musculoskeletal (MSK) physiotherapist once a week, a clinical pharmacist, a social prescriber and a mental health care coordinator. 	

- Throughout the inspection, the provider took immediate action to improve safety where we identified concerns and provided evidence to show what actions they had implemented.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

Glossary of terms used in the data.

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