

Care Quality Commission

Inspection Evidence Table

Andaman Surgery (1-541959708)

Inspection date: 09 August 2022

Date of data download: 4 August 2022

Overall rating: Good

Safe

Rating: Requires Improvement

At our previous inspection the practice was rated as good for providing safe services. We have rated the practice as requires improvement for providing safe services because;

- Staff vaccination was not maintained in line with current UK Health and Security Agency (UKHSA) guidance.
- The practice risk assessments had not fully identified and mitigated risks to ensure patients and staff were always kept safe from harm.
- There were some gaps in the practice system for the appropriate and safe use of medicines including those relating to medicines safety alerts.
- The practice did not always formally document clinical supervision to monitor the quality of care provided and identify any learning needs.

Safety systems and processes

The practice had some 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.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
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 professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes

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.	No ¹
Explanation of any answers and additional evidence: 1. The practice shared with us the information they held on the immunisation status of staff. However, this did not include the immunisation status for hepatitis B or chicken pox. Following the inspection, the practice told us they had taken immediate action, reviewed the guidance and asked staff for their information. Where required, risk assessments of job roles were undertaken.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 18 May 2022	Partial ¹
There was a fire procedure. Date of fire risk assessment: 16 March 2022	Yes
Actions from fire risk assessment were identified and completed.	Partial ²
Explanation of any answers and additional evidence: 1 & 2. The practice demonstrated they understood the need for risk assessments. We found the practice had some risk assessments in place, but there was a lack of oversight to ensure all actions were understood and completed. For example, the practice had undertaken their own legionella risk assessment which indicated a low risk of potential legionella in the water system. However, the practice records of the monthly water temperature checks lacked enough detail for the practice to be able to monitor changes and identify any potential issues. For example, the practice had not recorded the outlet where the sample was taken and not recorded the actual temperature of the water. The practice told us they would take immediate action and review the risk assessment of water documentation. The practice had a fire risk assessment and conducted fire checks. We reviewed the evidence and saw some gaps on the weekly fire checks which the practice told us were a result of staff absence such as leave. In addition, the practice told us they were increasing the number of fire wardens and reviewing the additional training the wardens may require.	

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.	Yes
Infection prevention and control audits were carried out.	Yes

Date of last infection prevention and control audit: 04 August 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.	Yes ¹
Explanation of any answers and additional evidence: 1. At the time of inspection, the waste collection and disposal contractor had a supply issue of sharps bins and to mitigate the risks, the practice was obtaining sharps bins themselves until the supply issue was resolved.	

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.	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	Yes

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial ¹
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.	Partial ²
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial ³
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. As part of our inspection and with practice consent, we used a suite of clinical searches and reviewed patients' records. We found inconsistencies in the quality of the record keeping and coding of medical records. For example, we identified patients who had a potential missed diagnosis of diabetes who had not been coded correctly. We found the practice did not consistently link medicines to conditions for clear and accurate information and monitoring. This meant other health professionals would not have access to clear and up to date information about the patient. In response to this, the practice told us they would implement more monitoring and training for staff. 2 & 3. We reviewed the practice's system for managing pathology results and found that most results were managed in a timely manner. However, on the day of inspection we found the practice system for managing test results had not ensured that all abnormal results had been identified and actioned. We found three results which had been received on 4 August 2022 and had not been reviewed until the day of inspection on 9 August 2022. The practice told us this was an oversight as a clinical staff member was not in for two days, the staff member was in on the day of the inspection and had contacted the patients to discuss their results. The practice took immediate actions to ensure all results that were indicated as abnormal, where the requesting clinician was absent, were reviewed without delay. 	

Appropriate and safe use of medicines

The practice did not have all the systems in place for the appropriate and safe use of medicines, including medicines optimisation.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.05	0.89	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	10.4%	10.6%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	6.36	5.76	5.29	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	241.7‰	196.3‰	128.2‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	1.29	0.99	0.60	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	13.2‰	12.2‰	6.8‰	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.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial ¹
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial ²
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 ³
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.	Partial ⁴
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.	Yes
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.	Yes
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:</p> <ol style="list-style-type: none"> 1. The practice told us, and staff confirmed, they had a clear process to ensure the competency of non-medical prescribing staff. Staff told us they had easy access to GPs for advice during all clinics and they also had discussions at clinical meetings which were minuted. However, the practice had not formally documented one to one supervision, to be able to monitor the quality of care provided and fully identify training needs for staff. 2. The practice was aware of a back log of annual medicines reviews (approximately 1000 patients who were prescribed four or more medicines or items). They explained that because of the restrictions during the COVID-19 pandemic, they had faced challenges to complete them as full medicines reviews as patients had not contacted them for some routine care and therefore the opportunity had been less to complete full structured medicines reviews. The practice now offered all patients in-person appointments unless telephone advice was requested by the patient. During our review of some medical records, we found that some staff had recorded that a full structured medicines review had been undertaken. However, the consultation record lacked sufficient detail to be assured that all medicines had been 	

Medicines management	Y/N/Partial
<p>considered by a staff member who held a prescribing qualification. The practice told us this was a coding error. They told us they would give training immediately to address this issue.</p> <p>3. We found information in the patient's record was mostly accurate in relation to medicines prescribed outside the practice. However, we found some examples where the detail from the correspondence had not been recorded into the patient prescribing record and therefore the information not available to others who may require it for their decision making.</p> <p>4. As part of our inspection and with the practice consent, we used a suite of clinical searches. Following these searches, we reviewed some patient records.</p> <p>We identified patients prescribed a high-risk medicine such as Azathioprine. Methotrexate and lithium and found all patients had been appropriately monitored.</p> <p>We identified 46 patients prescribed a potassium sparing diuretic (a medicine that may cause heart problems) and nine were identified as not receiving the appropriate monitoring. We reviewed five of these records and found three of these patients had not been managed appropriately.</p>	

Any additional evidence or comments
<ul style="list-style-type: none"> The practice was aware of the increase in 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 which had occurred before and during the COVID-19 pandemic. We noted that through their audit programme, the practice had monitored this and over the past 12-month period their prescribing had improved. The practice told us this will be monitored to ensure this improvement continues.

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:	6
Number of events that required action:	6
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff told us that when things went wrong at the practice, there was a culture of openness and support. Significant events were a standing agenda item at staff meetings and all staff were invited to attend meetings when significant events, outcomes and learning were discussed. 	

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

Event	Specific action taken
Urgent blood test result not actioned in a timely manner.	An investigation was carried out which identified that the abnormal test result was not reviewed by the duty GP in a timely manner. Learning was shared within the clinical meeting and the responsibility of the duty doctor was clarified again, including reviewing all blood test results that day.
Delay in 2-week referral being sent.	The practice identified a 2-week referral had not been processed. The referral was immediately processed and the hospital contacted to explain the error and ask for the appointment to be expedited. The practice investigated the issue and identified a staff member error. Learning was shared to remind all staff of the procedure to ensure tasks are completed before closing.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial ¹
Staff understood how to deal with alerts.	Partial ²
Explanation of any answers and additional evidence: <p>1&2. We found the practice did have a system in place for managing and acting on safety alerts, but the system had not ensured ongoing monitoring of some alerts. For example, our search</p>	

identified five patients aged over 65 years old who were prescribed a combination of medicines where additional risks should be discussed. We found no evidence that the risks had been discussed with these patients. The practice took immediate action and reviewed and contacted these patients.

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 not always fully 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.	Partial ¹
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
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 ²
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
Explanation of any answers and additional evidence: 1&2. We saw the practice held regular clinical meetings and staff told us they were proactive in their own learning to ensure they were up to date with current national guidelines. On the day of the inspection, the practice demonstrated that in many areas cohesive and consistent management of patient's conditions was in place. However, we found there was an inconsistent approach regarding the management of patients with diabetes or potential diabetes. This had resulted in the inconsistent recall of patients and incorrect coding of medical records.	

Effective care for the practice population

Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. The practice told us in the past 12 months, they had offered 196 health care checks to patients who were eligible. The practice told us they had been proactive in utilising 'every opportunity counts' to encourage uptake and completion of health checks, screening and reviews, and had in the last 12 months completed 409 NHS health checks. This ensured patients could be identified for proactive health and lifestyle support.
- All patients with a learning disability were offered an annual health check. The practice had 59 patients with a learning disability on their register and in the past 12 months had offered health checks. At the time of inspection 84% had been completed.
- End of life care was delivered in a coordinated and person-centred manner.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice offered longer appointments (40 minutes) for new registration for patients who were homeless, sex workers or part of the Travelling community.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- 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 a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. During the COVID-19 pandemic, these reviews were paused which created a backlog. The practice had responded by returning to providing all face to face appointments unless the patient chose to have telephone advice. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. As part of our inspection we reviewed patients with asthma and found 38 patients had been issued two or more prescriptions for steroids. We reviewed five of these records and found all five patients had not been issued with a steroid emergency information card and two were overdue their annual asthma reviews. Immediately following the inspection, the practice issued steroid cards to all patients that required them, including the patients we identified.

- Patients with asthma were offered an asthma management plan.
- We found the practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. However, we did see a lack of detail in patient records to be assured all medicines had been considered when a structured medicine review had been coded.
- The practice demonstrated how they identified patients with commonly undiagnosed conditions, for example, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. During our clinical searches we saw evidence of the management of chronic kidney disease. However, during our search we identified 13 patients with a potential missed diagnosis of diabetes. We reviewed five records and found three of these patients whose records had not been coded accurately. The practice took immediate action, reviewed all the records and contacted patients as appropriate.
- 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/Hip) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	51	55	92.7%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	57	59	96.6%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	57	59	96.6%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	57	59	96.6%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles,	64	71	90.1%	Met 90% minimum

mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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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 told us they had been proactive to encourage the uptake of children's immunisations for example, they contacted and discussed failed appointments on the same day with parents/guardians. The local health visitor attended the practice every two weeks to take part in a multi-disciplinary meeting and they also supported the practice and families to address barriers to vaccine uptake.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	79.3%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	70.5%	70.2%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	72.3%	70.4%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	54.5%	53.8%	55.4%	No statistical variation

Any additional evidence or comments

- The practice was aware that their cervical screening data was below the 80% target. They told us they recognised that patients who had declined their appointment might be anxious and so to support patients, they offered appointments with the wellbeing coach to discuss any concerns. The staff told us this had improved the uptake of cervical cancer screening.

Monitoring care and treatment

The practice had a 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.	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.	Yes

Any additional evidence or comments

- We saw examples of how the practice undertook quality improvement audits annually. For example, there was a joint audit completed by the practice and local primary care network which was designed to review the quality and appropriateness of referrals for suspected cancer investigations under the two week wait referral process.
- The practice undertook annual audits of the minor surgery procedures to monitor post infection rates and that patient consent was recorded. The practice performed at 100% each year.

Effective staffing

The practice was able to demonstrate 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">The practice had recently recruited new non-clinical staff. Staff who had recently started working at the practice told us they had received support during their induction period, including areas such as booking appointments to ensure the patient was booked with the most appropriate clinician.	

Coordinating care and treatment

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

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

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.	Yes

Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
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: <ul style="list-style-type: none"> Through the local primary care network, a wellbeing coach undertook sessions at the practice to support patients who needed extra support and guidance. For example, the coach had helped patients with housing and benefit claim support. We received positive feedback from patients regarding this service. 	

Consent to care and treatment

The practice always obtained that it 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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes ¹
Additional information 1. Records we reviewed showed completed forms contain all the appropriate detail required and had been in discussion with the patient and carers.	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated 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.	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

Patient feedback	
Source	Feedback
Health Watch Suffolk	In the previous 12 months we saw positive comments about the care and treatment provided by practice staff. There were 14 comments that rated the practice four and five stars out of five. There were three comments that rated the practice between one and three stars. Comments reflected the practice staff were kind and helpful.
Care Home Feedback	Feedback we received from representatives of care homes was mixed in relation to the service they received from the practice. The care home representatives gave positive feedback about the caring nature from practice staff such as reception and nursing staff, but there was some negative feedback about the attitude of GP's.
Patient Feedback	Patients we spoke with or who provided direct feedback through our 'give feedback on care' form online, gave positive feedback in relation to care and treatment. They gave positive comments in relation to consistency of care delivery and accommodating patients to see their preferred clinical practitioner.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	73.6%	86.4%	84.7%	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 (01/01/2022 to 30/04/2022)	76.1%	85.8%	83.5%	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 (01/01/2022 to 30/04/2022)	90.8%	94.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	71.8%	75.7%	72.4%	No statistical variation

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

Any additional evidence or comments
<ul style="list-style-type: none"> The practice held quarterly meetings, some via video conference and others at convenient locations for patients. All patients including the patient participation group (PPG) were able to attend these meetings. Patients we spoke with told us there an open culture for these meetings, where patients were able to give feedback both positive and negative about care and treatment given by the practice. In addition, the practice used these meetings as an opportunity to give patient education such as healthy lifestyle advice. External speakers had also been invited to various meetings. The practice reviewed feedback from these meetings and where appropriate made changes. For example, working with the local Healthwatch service to improve the experience service delivery from the practice to patients with dementia.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

Source	Feedback
Interviews with patients.	<ul style="list-style-type: none">• Patient feedback indicated they felt valued and treated like an individual by the practice and said they felt listened to and always involved in a person-centred approach to their care by the practice staff. They felt they were given full disclosure of treatment options and they were never left with questions surrounding their care.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	90.5%	92.0%	89.9%	No statistical variation

	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
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 120 patients on the carers register. This was 7.9% of the practice population.
How the practice supported carers (including young carers).	The practice supported carers by offering health checks and carers were prioritised for annual seasonal flu vaccinations. Carers were provided with details of accessible support groups and encouraged to access them. With appropriate consent, the details of identified carers were included in the medical record for the person for whom they cared and included in a care plan, written and attached to the medical record in case of hospital admissions.
How the practice supported recently bereaved patients.	When the practice had been made aware of a bereavement, they contacted the family within the first three days to offer condolences. Bereavement support information was shared with families and easily accessible information was shared in the practice and on the website for a wide range of bereavement support services.

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

Responsive

Rating: Good

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.	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.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 – 18.30
Tuesday	08:00 – 18.30
Wednesday	08:00 – 18.30
Thursday	08:00 – 18.30
Friday	08:00 – 18.30
Appointments available:	
Monday	08:00 – 18.30
Tuesday	08:00 – 18.30
Wednesday	08:00 – 18.30
Thursday	08:00 – 18.30
Friday	08:00 – 18.30

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none">• 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.• A GP was available on Monday, Tuesday or Wednesday evenings for working age patients to access appointments outside of their working hours.• Nurse, healthcare assistant and GP appointments were available to book Monday, Wednesday and Friday mornings for early access appointments also.• Additional nurse appointments were available for school age children so that they did not need to miss school.

- The Lowestoft Primary Care Network (LPCN) had a first contact physiotherapy service from the practice and patients could book a face to face or telephone review on a Monday afternoon and all-day Wednesday.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Practice staff told us patient appointments were available daily. We saw the practice appointment booking system which demonstrated readily available face to face appointments.

Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
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	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

Any additional evidence

- Patients told us their experiences of how the practice responded to their needs. They told us how the GPs during the COVID – 19 pandemic had visited them at home during a difficult time such as communicating information relating to a life limiting condition and supporting during end of life care.
- We did hear from some care home representatives who told us the practice had not always responded to the immediate needs of a deteriorating patient and had not called back in a timely manner. They told us this had led to some unnecessary ambulance callouts. The practice told us they had arranged to discuss these cases with the home to ensure learning was identified and where needed changes made.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	79.7%	N/A	52.7%	Significant Variation (positive)
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)	71.3%	61.7%	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)	62.3%	59.8%	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)	74.7%	77.0%	71.9%	No statistical variation

Source	Feedback
Patient Feedback	<ul style="list-style-type: none"> We spoke with patients who shared their personal experiences of receiving patient centred care. In particular we heard positive comments on how palliative care was delivered ensuring the patient and relatives were fully supported. Patients felt listened too and each process of the patient journey was explained.
NHS Choices	<ul style="list-style-type: none"> We received positive feedback regarding access to the practice on the telephone and the caring nature of staff shown to the patients during appointments.

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.	24
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial ¹
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: 1. We saw the practice took complaints seriously and responded to all complaints but did not always provide accessible information for the parliamentary and health service ombudsman on complaint responses, as per current national guidance. The practice website had information about the ombudsman displayed.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Locum GP attitude	The practice investigated the complaint, listened to the consultation call and saw evidence of the poor attitude and behaviour by the locum doctor. The patient was given an apology and the locum doctor was given the feedback.
Complaint response not given in timescale	Review of complaint by the practice showed the complaint response had been sent and not been received in the post by the patient. The practice immediately addressed and forwarded another copy and sent also via email to ensure delivery.
Poor staff attitude	Reviewed by practice and recognised the staff involved within the complaint had been perceived negatively. As a learning experience this was discussed and shared within the staff meetings. We found no ombudsman details supplied to response letter and addressed this with the practice.

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

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

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.	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

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

Source	Feedback
Non-Clinical Staff	Staff told us there was support from all departments and the leadership team were approachable. Staff were positive and told us they felt included; the primary care network staff told us they felt part of the practice team.
Clinical Staff	We were told by staff that support was easily accessible by the clinical and leadership teams and felt encouraged to undertake professional development.

Governance arrangements

Although there were clear responsibilities, roles and systems of accountability to support good governance and management these had not always been effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial ¹
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
1. The oversight and systems in place to assess and monitor some risk assessments had not been wholly effective. For example, in the management of legionella. We discussed this with the practice who explained that they had recognised that due to some staff capacity, not all risks had been reviewed and documented as frequently as they would like. They told us they were in the process of reviewing roles and responsibilities to address the support needed for the management team.	

Managing risks, issues and performance

Although there were processes for managing risks, issues and performance, they had not always fully identified all risks and actions to mitigate those risks.

	Y/N/Partial
There were some assurance systems which were regularly reviewed and improved.	Partial ¹
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.	Partial ²
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.	Yes
Explanation of any answers and additional evidence:	
1&2 During our inspection we found risk mitigation was generally in place, however we found some areas where this had not been wholly effective such as management of legionella and medicines management. The practice oversight and supervision of staff had not been wholly effective as we identified some poor coding by staff without a prescribing qualification indicating they had undertaken a structured medicines reviews of patients' medicines. The practice gave us assurance these staff had not prescribed medicines.	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic.

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

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

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.	Yes
The practice advised patients on how to protect their online information.	Yes

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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none">• The Patient Participation Group was positive in their feedback and felt supported by the practice. They told us the GP's and practice manager were always present at the meetings and engaged in the conversations and discussions.• The Patient Participation Group shared with us their plan for fundraising to buy equipment for the practice, which would not usually be provided in the primary care setting.

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

Examples of continuous learning and improvement

<ul style="list-style-type: none">• The practice recognised that healthcare service delivery had changed as a result of the COVID-19 pandemic and as a result, were working with staff to develop new roles and responsibilities. As part of this review, the practice was aware of the additional training and support staff would need. For example, reception staff were receiving additional training to undertake other non-clinical roles, for example the recall of patients for reviews.
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Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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.
- %o** = per thousand.