

## Inspection Evidence Table

Dr Okeahialam and Partners (1-557606767)

Inspection Date: 1 & 4 September 2023

Date of data download: 22 August 2023

## Overall rating: Requires Improvement

We have rated this practice as requires improvement because we identified concerns in respect of:

- medicines management
- supporting patients with specific health conditions
- the actioning of medicines alerts
- low rates of cancer screening and child immunisations
- low levels of disability health checks undertaken
- annual appraisals for all staff were not up-to-date
- patient accessibility

## Context

The practice is situated within the NHS West Yorkshire Integrated Care Board (ICB) and delivers Primary Medical Services (PMS) to a patient population of around 18,650. The practice is part of a wider network of 4 GP practices, the Bradford North West Primary Care Network (PCN).

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the second lowest decile (2 of 10). The lower the decile, the more deprived the practice population is relative to others. According to the latest available data, the ethnic make-up of the practice area is 45.5% Asian, 48.5% White, 1.5% Black, 2.5% Mixed, and 2% Other.

The age distribution of the practice population closely mirrors the local PCN averages. There are more patients registered at the practice aged 29 and under than the national average.

## Safe

## Rating: Requires Improvement

We have rated safe as requires improvement because we identified issues which included:

- Systems to monitor patient's medicines were not always followed.
- Evidence of the potential missed diagnosis of diabetes.
- The failure to fully action medicines and patient safety alerts.

### Safety systems and processes

**The practice had 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.	Partial
Explanation of any answers and additional evidence: The provider had appointed clinicians to act as safeguarding leads for both adults and children.  The provider had measures in place to closely monitor children who were of concern, but had not reached the threshold for referral to safeguarding teams.  The provider had recognised that effective safeguarding required additional administrative support and had a dedicated staff member to specifically provide this. Duties included reviewing caseloads, running monitoring reports, developing systems and processes for coding vulnerable patients, and assisting in the timely completion of correspondence.	

Safeguarding was a fixed agenda item at weekly meetings, as well as being discussed at specific safeguarding meetings.

The provider gave us examples of when they had acted to support vulnerable patients in the community, this included issues which involved modern slavery concerns.

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:                      The provider had a recruitment policy, and recruitment had been undertaken in line with regulations. However, it was noted that it lacked some specific details. For example, it failed to specify the number of references required for staff, and in what format these would be accepted.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment:	September 2023
There was a fire procedure.	Yes
Date of fire risk assessment:	All sites had received a fire risk assessment in 2022.
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:                      The provider had developed a fire safety policy. We saw that fire safety training had been undertaken, and that staff were appointed to key emergency roles such as fire marshals.</p> <p>Sites had been subject to health and safety audits. For example, the last audit of the Leylands site had been undertaken on 16 December 2022.</p>	

**Infection prevention and control**

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

	Y/N/Partial
Staff had received effective training on infection prevention and control (IPC).	Yes
Infection prevention and control audits were carried out.	Yes

Date of last infection prevention and control audit: August 2023	Yes
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
<p>Explanation of any answers and additional evidence:  The provider had appointed leads for IPC management and oversight. They had processes in place which included:</p> <ul style="list-style-type: none"> <li>• Site IPC audits and checks.</li> <li>• Hand hygiene audits.</li> <li>• An annual audit of minor surgery outcomes.</li> <li>• Supporting protocols and procedures which included a clinical waste policy, sepsis policy and sharps policy.</li> </ul> <p>From records we reviewed we saw that all staff had completed mandatory IPC training.</p> <p>Whilst the premises and equipment were found to be in a clean and well-maintained condition, there were no individual cleaning schedules in place for consultation rooms and equipment.</p>	

### 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.	Yes
<p>Explanation of any answers and additional evidence:  The provider had developed a safe staffing procedure which outlined the required staffing levels for the safe and effective operation of the service. This included all grades of staff and outlined required levels of supervision and support.</p> <p>The provider had induction processes in place which included induction checklists, rotas and specific role information. The provider also had a locum pack to ensure additional staff brought into the practice to provide cover, had the required information to deliver care safely and effectively.</p>	

We noted that some staff reported that workloads were high at times, which impacted on other aspects of their time in the practice such as the ability to attend meetings. In mitigation we saw that the provider was actively seeking to recruit staff to join the practice, and had developed new ways of working to increase capacity. This included the development of a palliative and housebound care team who led on this area of activity. We were informed that the provider was actively engaged in recruiting additional staff to the nursing team.

There was emergency medical equipment held at all sites, for example oxygen and an automated external defibrillator (AED). Staff were aware of their location. We saw there were regular checks in place.

Staff had undertaken training to identify deteriorating patients, and were aware of 'red flag' presenting symptoms, for example patients with shortness of breath, and knew what action to take if they encountered a deteriorating or acutely unwell patient. Staff told us they would contact the duty doctor or another clinician if they had any concerns.

Via an initial complaint the provider had identified a delay in a 2-week wait cancer referral. After this had been investigated, we saw that staff awareness had been raised regarding the correct process to be used, and safety netting had been put in place. This involved a weekly audit of referrals to track progress and informing patients to contact the provider should they have not received an appointment within 2 weeks. No harm was associated with the original delay.

### Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
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, 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:            We saw that there were 1,755 incoming correspondence items that had not been fully completed (the provider usually received around 1,000 incoming correspondence items per week). The provider was aware of this issue and had put in place measures to reduce risk associated with this. All correspondence had been reviewed for actions and any associated risks were assessed to ensure that urgent or important letters were coded as a priority. Risks were therefore managed, and the provider was taking steps to reduce numbers.</p>	

The provider's clinical system had 1,150 open tasks (used to communicate with others and organise actions). We discussed this with the provider who informed us that they would examine this further with the aim of reducing this number of open and outstanding tasks.

### Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	1.03	1.01	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)	5.1%	5.1%	7.8%	Tending towards 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)	5.32	4.70	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	95.2‰	122.3‰	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)	0.34	0.39	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	6.7‰	7.2‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	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
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.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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.	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, including from clinical searches. As part of our inspection a CQC GP specialist advisor (SpA) undertook searches of patient records on the practice's clinical records system. Findings from these searches included:</p> <p><b>Medicines Reviews</b></p> <ul style="list-style-type: none"> <li>The provider had undertaken 1,977 reviews in the previous 3 months. Of the 5 records we checked we found that these were of mixed quality, but generally satisfactory. 1</li> </ul>	

record checked lacked detail and had only been coded that a review had been undertaken with no further details, whilst another had been mis-coded as a medicines review when a diabetes review had been undertaken.

### **Medicines which required monitoring including high risk medicines**

Performance regarding medicines monitoring within the practice was mixed.

- We found that the monitoring of patients in receipt of Azathioprine (used to treat conditions that affect the immune system such as rheumatoid arthritis) was generally well managed. However, it was noted that 1 patient had recently had their bloods checked, but that only the full blood count had been checked rather than all the required tests.
- Our searches showed that 2 patients in receipt of Lithium (a mood stabilising medicine) had potentially not been monitored. When we examined these further, we saw that 1 patient had been booked in for monitoring, and 1 patient was only just overdue monitoring by 14 days and was to be recalled.
- Of 229 patients prescribed gabapentinoids (used to treat epilepsy, anxiety, and nerve pain), we identified 30 patients who had potentially not received the required monitoring. Of 5 records we checked in detail, we found that 2 patients had not been reviewed during the previous 12 months. However, it was also noted that in 2 patient records the reason for prescribing was unclear. Additionally, in 2 patient records for women of childbearing age, had not been given pre-conception advice regarding the risks taking the medicine could pose to the developing foetus.

### **Potential missed diagnosis of diabetes**

- We identified 41 patients who had a potential missed diagnosis of diabetes. Of the 5 records we checked we found that 1 patient had a high HbA1c in April 2022 but had not been informed of this, and was not retested until March 2023 (this patient was currently awaiting another reading). 1 patient coded as having gestational diabetes had not had their bloods tested since the initial diagnosis and coding.

Following the inspection, we were informed by the provider that they had reviewed 375 patient records in relation to medicines management and long-term conditions monitoring, and had arranged necessary actions to be undertaken.

The provider had appointed 2 experienced members of the clinical team as medicines leads. One of these was an in-house pharmacist who acted as a first point of contact and support for medicines queries.

The provider managed medicines via:

- The development of standard operating procedures and policies.
- Clinical audit of prescribing practice.
- Clinical supervision and support for non-medical prescribers and GP registrars.
- The use of pop-ups within the clinical records system, to alert staff when prescribing or repeat prescribing should not occur due to monitoring being out of date.
- The use of a prescription button on the clinical system to ensure the safe prescribing of antibiotics to children. This took into account the age and weight of the child and automatically calculated the dose. This was put in place following learning from a previous significant event. In addition, the provider had integrated



the FeverPAIN score into prescribing processes which calculated the likelihood of Streptococcal Pharyngitis throat infection and need for an antibiotic prescription.

Feedback from a residential care home stated that on occasion medicines instructions had been rather unclear, and required them to contact the provider to clarify them.

**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:	20
Number of events that required action:	20
Explanation of any answers and additional evidence: All incidents were discussed, and their potential impact risk rated. Incidents and learning events were formally discussed at a quarterly meeting, and if more urgent they were discussed at weekly protected learning time meetings.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Due to unexpected sickness absence a GP registrar was the only GP working at a site for a single session. The registrar was therefore unsupervised, although support was available at other sites.	Following identification of this incident a new process was implemented to improve communication to effectively report to senior managers when potentially less experienced staff were left unsupported. No harm was identified from this event.
Delayed safeguarding referral by registrar.	The clinician concerned reflected on the incident for self-learning. In addition, the induction information for staff was improved to reiterate the safeguarding processes to be followed. The safeguarding referral subsequently was made on identification of the incident and no harm resulted from the delay.

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> <p>The provider was not able to fully demonstrate that medicine and drug safety alerts had been handled appropriately or that the necessary actions had been taken. Our remote clinical searches showed that:</p> <ul style="list-style-type: none"> <li>• 9 patients were in receipt of high dose simvastatin (used to reduce cholesterol) and a calcium blocker amlodipine (used to treat hypertension). This had been subject to a combination drug alert as the amlodipine increases the concentration of simvastatin. The alert required that an alternate statin should be prescribed, or that simvastatin should be prescribed at a lower dosage. Risks should also be discussed with patients. In 5 records we examined we saw that in 1 case the amlodipine had been reduced, but needed to be either stopped or the simvastatin changed to an alternative. In 4 cases there was no evidence that risks associated with the use of these drugs in combination had been discussed with patients and the patients continued to be prescribed at a higher dose.</li> <li>• 2 patients of childbearing age had been prescribed pregabalin (used to treat epilepsy, anxiety, and pain). The use of this medicine had been recognised to slightly increase the risk of congenital malformations if used in pregnancy. This had been subject to an alert which required providers to discuss the risks of using the medicine if they prescribed this to women of childbearing age, and to give contraception advice. In these 2 cases we saw no evidence of contraceptive advice in the care record.</li> </ul> <p>We saw that the provider had processes in place for the receipt, assessment and dissemination of medicines alerts and these were discussed at the weekly protected learning time meetings.</p>	

## Effective

## Rating: Requires Improvement

We rated effective as requires improvement as we identified concerns which included:

- The potential missed diagnosis of diabetes.
- Patients with hypothyroidism had not been managed effectively.
- Cancer screening outcomes and child immunisation rates were below national targets.
- Only 45% of patients with a learning disability had received an annual health check in the previous 12 months.
- Annual appraisals had not been held for all staff within the required time period.

We saw that the provider had recognised local challenges in respect of cancer screening and child immunisation performance and needed to improve. They had therefore undertaken specific engagement activity to raise participation in these programmes. However, there was not yet sufficient evidence to demonstrate whether these actions had been successful. Therefore, the rating is requires improvement, as ratings depend on evidence of impact and must reflect outcomes that people were receiving at the time of inspection.

*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 fully assessed, and care and treatment was not delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
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.	Partial
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
<p>Explanation of any answers and additional evidence:  As part of our inspection, CQC's GP specialist advisor (SpA) undertook in-depth searches of the practice's clinical system. The clinical searches found that not all patients had been consistently reviewed and monitored, and that not all patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.</p> <p><b>Potential missed diagnosis of diabetes</b></p> <ul style="list-style-type: none"> <li>We identified 41 patients who had a potential missed diagnosis of diabetes. Of the 5 records we reviewed, 1 patient had a high HbA1c result in April 2022 but had not been informed of this, and not retested until March 2023 (and who was currently awaiting another reading). 1 patient coded as having gestational diabetes who had not had their bloods tested since the initial diagnosis and coding.</li> </ul> <p><b>Long-terms Conditions Management</b></p> <ul style="list-style-type: none"> <li>Hypothyroidism – 27 out of 470 patients had not potentially been monitored appropriately. Of the 5 records we reviewed in depth, all 5 patients had not received the required monitoring. It was though noted that whilst 2 patients had recent blood tests the level of thyroid stimulating hormone had not been checked.</li> </ul> <p>Notwithstanding the above, our searches of the clinical system also showed that patients with asthma, chronic kidney disease stages 4 and 5, and those with diabetic retinopathy had been managed in line with guidance.</p> <p>Following the inspection, we were informed by the provider that they had reviewed 375 patient records in relation to medicines management and long-term conditions monitoring and had arranged necessary actions to be undertaken.</p> <p>The provider had access to a live clinical protocol system called GP Assist. These were shared across GP practices in Bradford and formed part of their clinical process pathways. However, the provider had recognised that GP Assist failed to cover all areas of clinical activity. As a result, they had developed their own protocols such as a hypertension protocol. These in-house protocols were regularly reviewed and updated.</p> <p>Protocols and procedures were available on their knowledge, compliance, and workforce management platform.</p>	

## Effective care for the practice population

<b>Findings</b>
<p>Those identified received assessments of their physical, mental and social needs.</p> <p>Health checks, including frailty assessments, were offered to patients over 75 years of age.</p>

Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

Patients had access to appropriate health assessments such as new patient health checks. For patients aged 40 to 74 NHS health checks were available on request.

There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

Patients with a learning disability were offered an annual health check. The provider had 201 patients on their learning disability register. In the previous 12 months, 90 health checks (45%) had been undertaken. In the past invitations to these health checks were ad hoc, this process had been changed to bring it in line with the management of long-term conditions, and as a result invitations were sent out annually in the patient's month of birth. The provider confirmed that all patients who were not housebound or living in residential care, and who had a birth month in May, June or July had either received a health check or offered a health check.

End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.

The provider had developed a dedicated palliative and housebound team. This was composed of a team of doctors who undertook morning home visits. This allowed more effective, and dedicated care planning, and led to a net gain in other appointments as GPs not making home visits were able to see more patients.

The service had formed an acute care team. This was a multidisciplinary team composed of senior GPs, GP registrars, pharmacists, an advanced nurse practitioner and a paramedic. Their duties involved triaging and then dealing with acute demand which had not been covered by routine appointments. The team worked in the afternoon and key recognised benefits included:

- Via triage to better identify needs and focus resources.
- Triaged improved resource allocation. For example, a medication-based query could be dealt with by a pharmacist rather than taking up an appointment with a GP.
- As acute work was seen as being individually challenging at times by working as a team clinicians felt better able to support one another, which had a positive impact on staff.

The provider had developed a care home team which supported patients in 8 residential care settings. The team was led by a senior GP and had proactive contact with homes on a weekly basis. Benefits of this approach included proactive rather than reactive care delivery and improved continuity of care.

The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

The practice had a system to identify people who misused substances.

The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.

Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

The provider had formed a long-term conditions team. This was composed of administrators who made proactive contact with patients to arrange necessary reviews and follow-up any required actions. The provider had seen that the team had made a positive impact on supporting patients with long-term conditions and felt that this approach could be extended to other areas such as improving child immunisation rates by making proactive contact with parents to promote uptake.

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. For example, staff had received additional training in diabetes and asthma care.

GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Adults with newly diagnosed cardio-vascular disease were offered statins.

Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

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)	221	246	89.8%	Below 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)	202	266	75.9%	Below 80% uptake

The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	203	266	76.3%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	204	266	76.7%	Below 80% uptake
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)	247	283	87.3%	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
<p>The practice was aware of their low child immunisation performance. The clinical team understood a number of social and cultural barriers which may prevent children being presented for immunisation. When parents or guardians did not present their child for vaccination, the provider offered further appointments and support. When needed they worked with other partners such as health visitors to promote and increase uptake. In addition to these actions the provider had examined other methods of improving uptake. These included:</p> <ul style="list-style-type: none"> <li>• Planning to hold an event prior to Christmas 2023 to discuss with parents and guardians child immunisations, and from this to seek to identify from their perspective concerns or barriers (this approach had been undertaken with a recent event held by the provider which sought to improve cervical screening).</li> <li>• Using a questionnaire to assess parent and guardian views on child immunisations and using intelligence from this to improve uptake. Following the inspection we were informed that the questionnaire had been posted on the provider website.</li> <li>• Making proactive contact with parents using a similar approach taken by the long-term conditions team who facilitated the organisation of reviews and other patient contacts.</li> </ul>

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	57.6%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year	61%	N/A	70.3%	N/A



coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)				
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). (3/31/2023 to 3/31/2023) (UKHSA)	52.9%	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)	61.7%	59.4%	54.9%	No statistical variation

Any additional evidence or comments
<p>The provider recognised the areas of lower performance in relation to cancer screening. They had put in place measures to improve performance. These included:</p> <ul style="list-style-type: none"> <li>Breast and bowel cancer – the provider continued to promote participation in screening opportunistically. In addition, staff contacted patients who had not participated in the bowel cancer screening programme and supported them through the process.</li> <li>Cervical screening – the provider held a women’s health event in June 2023. All women aged 45-55 years old were invited to attend the event which looked at healthy lifestyles. At the event the provider collected information from patients about their views on cervical screening (in addition, a questionnaire was also sent out to all women in the screening age range). The information collected was analysed and written up as an audit. The results from the 227 responses gave the provider valuable insight into potential barriers and ways to improve uptake. Barriers identified included difficulties in booking an appointment, fear of the procedure, and a lack of understanding. Suggested ways of improving participation included awareness raising, and giving assurances that a female practitioner would undertake the procedure. As a result of this feedback the provider produced a frequently asked questions document which could be sent to patients via text with the next screening invitation. The provider planned to have this translated into Urdu and other languages and had developed a poster to be added to the practice TV screens. Patients were also opportunistically offered cervical screening and were able to access screening appointments via the extended hours service.</li> </ul>

### Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> <li>• Clinical audits – we saw that a comprehensive programme of clinical audits had been undertaken by the provider. This included an audit of minor surgery infection rates. This showed that up to 2019 their infection rate was about 3%. After this the provider introduced the use of alcohol gel in the hand hygiene protocol after hand scrubbing with soap and water. Further audits showed a reduction in post operative infections, in 2022 it was 1% and up to September 2023, they had not recorded any infections. An audit of non-vitamin K antagonist oral anticoagulants (NOACs these are used to help prevent harmful blood clots from forming in your blood vessels) undertaken in 2022 assessed if patients were on the correct dosage. Of 154 patients in receipt of NOACs, 29 were identified as being on an incorrect dosage. All 29 patients had their dosages corrected and awareness was raised amongst clinicians.</li> <li>• Analysis of significant events/learning events/complaints. The provider identified a delay in a 2-week cancer referral made by a locum. Following an investigation into the incident the locum pack was reviewed and updated, to ensure processes to be followed were clearly outlined. In addition, safety netting processes were put in place and audits were run on cancer referrals on a weekly basis to identify any new issues.</li> </ul>	

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	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.	Partial
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
<p>Explanation of any answers and additional evidence:  We saw evidence which showed that GPs had all completed their professional appraisals. However, appraisals for other members of the practice team, which included members of the nursing team, and administration and reception teams were not up to date. This had</p>	

been recognised by the provider, and they told us that they planned to have undertaken appraisals for these groups of staff by the end of September 2023.

Induction processes had been established by the provider. This included a specific induction for GP registrars.

Following receipt of a concern the provider had examined the level of training and support provided to healthcare assistants. As a result of this a training plan had been developed and new standard operating procedures were put in place which gave additional advice. For example, they had produced a procedure on how to interpret clinic blood pressure readings.

We were informed by some staff that communication and feedback routes within the nursing team were limited. We heard from the provider that they were aware of this, and in response the nurse manager had put in place measures to improve communications. We saw that nurse meetings were now minuted, and it was planned for other members of the nursing team to attend the weekly protected learning time meetings of a rotating basis.

The provider shared with us future plans to link appraisals more closely with their training and competency framework.

### 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
<p>Explanation of any answers and additional evidence:                      The practice, through the primary care network (PCN), had access to additional support which included paramedics and pharmacy staff.</p> <p>The provider held regular meetings with stakeholders to support patients near the end of life or who needed additional support.</p>	

### 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
<p>Explanation of any answers and additional evidence:</p> <p>The provider worked closely with community and voluntary sector partners. For example, they were able to signpost and refer patients to a community and voluntary sector provider who worked in Bradford, for several specific support services. This included advice and support regarding cost-of-living pressures and wider health and wellbeing concerns.</p> <p>The provider had organised and run a successful women's health event which raised community awareness of several key health topics such as cancer screening and menopause support. The provider planned to build on this approach to improve child immunisations uptake and wider child health.</p>	

### 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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed a sample of patient records where do not attempt cardiopulmonary resuscitation (DNACPR) orders were in place. We found evidence of a patient discussion, agreement of reasons for the decision, and confirmation whether or not the patient had capacity to consent to DNACPR.</p> <p>Staff we spoke with, or received feedback from, had a good understanding of the principles of consent.</p>	

## Caring

Rating: Good

### Kindness, respect and compassion

Staff generally treated patients with kindness, respect and compassion.  
Feedback from patients was mixed 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
Patient contact with CQC	We received feedback from a patient who told us that they found some staff unhelpful and abrupt.
Observations during the inspection	During the inspection we saw that patients were treated in general with kindness and concern. However, we noted one occasion when a patient left the reception at a practice site frustrated, and with their issue unresolved.
Staff interviews	Staff we interviewed and spoke with mentioned the importance of prioritising compassionate care to patients.
NHS website reviews	Results regarding the provision of caring services and staff were generally positive with 15 reviews being positive about the care and treatment received and staff attitude. Responses from 5 patients were more negative regarding poor care, communication, and staff attitude.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	86.0%	81.6%	85.0%	No statistical variation

The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)	78.9%	80.3%	83.8%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	90.8%	90.8%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	67.3%	65.3%	71.3%	No statistical variation

#### Any additional evidence or comments

The provider was aware of their GP Patient Survey results and reviewed these as part of their approach to quality improvement.

The provider had not been sending the link to the NHS Friends and Family Test survey to patients, but we were informed that they planned to reintroduce this. Instead, the provider had feedback details on the front page of their website, and had a link set up in their clinical system which texted the patient to ask for feedback and which was linked to official NHS website. In addition, staff had the opportunity to give rapid feedback to the management team using a feedback button embedded in the provider's clinical system. This included feedback and comments from staff, and front-line staff were able to capture feedback from patients regarding the care that they had received.

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

#### Any additional evidence

The provider had undertaken a detailed patient survey regarding cervical screening and used this to identify potential barriers to patients attending screening appointments, and through this put in place improvements such as the development of an awareness raising leaflet.

## 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
Explanation of any answers and additional evidence: Easy read, translated, and pictorial materials were available.  Some staff had language skills which they used to converse with patients.	

Source	Feedback
Observations during the inspection.	We observed patients being supported and advised by reception staff.
Patient contact with CQC	One patient informed us when they had been well supported by a member of the practice reception team.

## National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	85.6%	86.8%	90.3%	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
Explanation of any answers and additional evidence: The practice captured patient communication needs on registration and during clinical consultations.	

Staff we spoke with knew how to access interpretation and translation services if required.

Carers	Narrative
Percentage and number of carers identified.	2.5% of practice population (471 carers identified).
How the practice supported carers (including young carers).	The provider recognised that carers were a vulnerable group and had recently visited a dementia carers forum meeting to try to help and support them. Carers were identified at new patient registration and opportunistically during consultations. Carers were offered support such as consultations and vaccinations.
How the practice supported recently bereaved patients.	The provider had recently reconfigured a role for a member of the existing reception team member who acted as a bereavement coordinator. The coordinator supported those recently bereaved, and was able to make referrals and signpost to appropriate services. They also kept in regular contact with those bereaved for several months to continue to offer support. The provider also sought to meet the cultural needs of the local population in relation to timely death certification when appropriate.

### 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: Requires Improvement

We rated the provider requires improvement due to concerns raised by the public concerning access to the service, and in particular difficulties contacting the provider by telephone. In addition, we identified some concerns regarding complaint handling.

We saw that the provider had recognised that it had experienced challenges related to patient access, capacity and demand, and complaints handling. They had therefore taken actions to improve some of these areas by restructuring services, increasing appointment numbers, planning improvements to the telephony system, and reviewing complaints handling. However, there was not yet sufficient evidence to demonstrate whether these actions had been wholly successful. Therefore, the rating is requires improvement, as ratings depend on evidence of impact and must reflect outcomes that people were receiving at the time of inspection.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	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 and Branch Opening Times	
Day	Time
Opening times:	
Monday	8.30am - 6pm
Tuesday	8.30am - 6pm
Wednesday	8.30am - 6pm
Thursday	8.30am - 6pm
Friday	8.30am - 6pm
	The practice closed on Thursdays between 1pm and 4pm for training and learning.



	Telephone calls to the practice were diverted at this time to another provider.
Appointments available:	
Monday	8.30am -12.30pm and 1pm – 5pm with the duty doctor available until 6pm.
Tuesday	8.30am -12.30pm and 1pm – 5pm with the duty doctor available until 6pm.
Wednesday	8.30am -12.30pm and 1pm – 5pm with the duty doctor available until 6pm.
Thursday	8.30am -12.30pm and 1pm – 5pm with the duty doctor available until 6pm.
Friday	8.30am -12.30pm and 1pm – 5pm with the duty doctor available until 6pm.

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

Extended access appointments were available to patients via the Bradford Care Alliance. They offered appointments from Monday to Friday 6.30pm to 9.30pm, Saturday 9am to 5pm, and Sunday 10am to 2pm. These appointments were delivered at local hubs and not at the provider locations.

The provider delivered care to patients who resided in 8 care homes and nursing homes, this included individuals with a learning disability. The practice had appointed a clinician to lead on care provision for these patients. Care provided included weekly contacts with the locations, and visits to the homes. In August 2023, the practice had established a care home team under the lead clinician, who was supported by GP registrars. This allowed the provider to increase allocated clinician time with this vulnerable group and offered increased continuity of care, as well as giving increased capacity to undertake reviews. The practice also offered COVID spring boosters to care home patients, despite this being outside the core contract that they were tasked to deliver.

The provider had recognised the need to both increase capacity and improve services to specific groups. It had therefore developed specific teams and services to better meet local need and demand. This included:

- An acute care team.
- A palliative care and housebound team.
- A care homes team.
- Long-term conditions team.

The provider held twice monthly sexual health clinics, which included contraceptive implants. Other services delivered by the provider included physiotherapy, joint injections and minor surgery.

Patients had a named GP. Lead clinicians had been appointed to key leadership roles. Examples included safeguarding, prescribing and dementia.

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.

The practice liaised regularly with community services to discuss and manage the needs of patients with complex medical issues.

Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

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 had mixed views on their ability 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>The provider was aware of the results of the latest GP Patient Survey (response rate 25% - 148 responses from 584 surveys sent out which equated to 0.7% of the practice population). In particular, patient feedback regarding the ease of being able to contact the GP practice by phone had fallen significantly from 62.7% in 2021 to 20.4% in 2023. In response to this the provider had, or had planned to take the following action:</p> <ul style="list-style-type: none"> <li>Seeking to increase capacity to meet demand by the introduction of role specific teams and duties, and updating reception team protocols. This included an acute care team, a palliative and housebound care team, long-term conditions team, and the appointment of a bereavement coordinator. In addition, the provider had also upskilled healthcare assistants to improve long-terms conditions care.</li> </ul>	

- Increasing numbers of clinical appointments available. Unverified data provided by the team, showed that in 2019/20 the provider offered 11,073 in-house appointments (exclusive of home visits and extended hours access appointments), in 2022/23 this had increased to 13,237 in-house appointments, an increase of over 16%.
- Plans were in place to upgrade the telephony system during quarter 4 2023/24. This was planned to improve the patient experience via improved call access and the offer of a call back facility. The provider sent us evidence of the planning work undertaken for this project.

The provider reviewed access and appointments at monthly meetings.

The provider had undertaken audits into access and appointments.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	20.4%	N/A	49.6%	Significant variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	39.4%	47.5%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	39.2%	47.9%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	58.9%	70.6%	72.0%	Tending towards variation (negative)

Source	Feedback
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NHS.uk website (formerly NHS Choices)	Of 37 reviews left on the NHS website 8 mentioned difficulties in accessing services, whilst 7 reviews specifically noted good access to services.
Feedback from care homes contacted by CQC	We spoke with 2 care home representatives. They told us that they received a good service from the provider and found the weekly contacts with the practice supportive to their needs, and the needs of residents. In one case it was noted that sometimes it was difficult to contact the provider by telephone.

### 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.	26
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the time of inspection, the complaints form had been temporarily removed from the provider website for review. Patients who wished to complain were informed to contact the provider directly. Feedback from some patients indicated some dissatisfaction with complaints handling and the ability to make a complaint or raise a concern.</p> <p>The provider acknowledged that after the loss of their previous practice manager in early 2022 that complaints identification and handling had suffered. However, they now felt that this was back on track. The complaints we reviewed on the day confirmed this.</p> <p>We saw that the provider reviewed complaints on a regular basis, and used these to make improvements to services.</p>	

Example of learning from complaints.

Complaint	Specific action taken
Complaint from patient regarding delay in a cancer referral.	This was identified as an error made by a GP locum and was linked to their knowledge and understanding of

	<p>the provider's processes. After an investigation into the complaint (and subsequent logging as a significant event) we saw that GP locum awareness had been raised regarding the correct process, and that the locum pack had been updated. In addition, safety netting had been put in place for the referral process. This involved a weekly audit of referrals to track their progress, and also informing patients to contact the provider should they have not received an appointment within 2 weeks. No harm was associated with the original delay.</p>
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**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
<p>Explanation of any answers and additional evidence:</p> <p>In recent years the provider had experienced a number of challenges. These included:</p> <ul style="list-style-type: none"><li>• The impact of the COVID pandemic which had left staff feeling exhausted and with low morale.</li><li>• In 2022 over a 6-month period the provider lost 4 key members of the management team.</li><li>• Infrastructure improvements such as building extensions, refurbishments, and urgent repairs had occurred during this time.</li><li>• New ways of working had needed to be introduced.</li><li>• Becoming aware that balancing clinical and managerial workloads were proving difficult for GP partners.</li></ul> <p>To meet these challenges the provider took time to analyse and plan effective responses. These included:</p> <ul style="list-style-type: none"><li>• Spending time with operational teams and learning from staff experiences and viewpoints.</li><li>• Adopting a new immediate staff feedback system using a quick to use button embedded in their clinical system (Report A Positive/Problem). Themes from this feedback were collated and used as intelligence for planning and action.</li><li>• Holding more structured management meetings backed by new leadership structures and performance and quality management processes. Performance and quality improvement approaches included learning events analysis. The provider used a collaboration tool that organised workstreams into simple, easily understood boards which were used to inform the management team of what had been worked on, by whom, and what progress had been made.</li><li>• Recruitment of new staff and embedding new structures and teams. For example, increased capacity through the development of dedicated care teams.</li></ul>	

## 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>Due to recent changes in staff and limited opportunities for engagement some staff and other stakeholders had had limited opportunities to develop or input into the strategic direction of the organisation.</p> <p>The provider held a range of meetings across the organisation. This included:</p> <ul style="list-style-type: none"> <li>• Management “Cup of Tea” meetings – held at lunchtime on Mondays.</li> <li>• Management protected learning time meetings – held weekly to discuss management issues, incidents, and learning point.</li> <li>• Nursing team meetings – these had been re-established and were held monthly.</li> <li>• Administration and reception team meetings which were held monthly.</li> <li>• Other meetings such as access and appointment review meetings and operations meetings.</li> </ul>	

## 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p>	

Some staff we spoke with or received feedback questionnaires from told us that they felt that they were able to raise concerns. However, some staff told us that due to poor communication and limited feedback, they felt that some concerns may not have been given organisational consideration.

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

Source	Feedback
Staff questionnaire return	Felt well supported and that managers and partners were all approachable. They gave an example when the organisation had supported them when they had struggled with their workload.
Staff questionnaire return	A member of the clinical team felt that they had received variable levels of support, and that communication and feedback was limited across the team in which they worked.

### Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

### Managing risks, issues and performance

**There were effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
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.	Yes
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
<p>Explanation of any answers and additional evidence:  The provider had a detailed performance management system and underpinning processes in place. We saw that performance was closely monitored at senior level. Weekly management meetings took partners and other staff away from clinical duties, and allowed them the time to devote to operational management.</p> <p>We saw how the provider's approach to quality improvement had a central role in operational planning, learning, and the development of services.</p> <p>Senior staff had organisational leadership and team management roles.</p>	

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	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
Staff are supported to work remotely where applicable.	Yes

**Engagement with patients, the public, staff and external partners**

**The practice had some involvement with the public, staff and external partners and used this to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group (PPG).	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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The level of involvement with the public, staff and external stakeholders and partners was variable. We saw that there were some mechanisms for feedback and engagement. For example, the use of a button (RAP) on the clinical system to capture staff views and concerns, and sending SMS links to patients to leave their views of the services they had experienced on an NHS website.</p> <p>However, we heard from some staff members that communication within the organisation was sometimes poor, and feedback from the management team was limited at times.</p> <p>In addition, whilst there was a PPG, the provider noted that this struggled to be fully effective and representative. Feedback from a current PPG member indicated that they felt that the PPG had not been listened to in the past, and felt that they had been excluded from participating in the inspection.</p> <p>We discussed these concerns with the provider who told us that they recognised and understood some of the issues raised by staff and the PPG. In respect of staff feedback regarding poor communication and feedback opportunities the provider has reinstated nursing team meetings on a regular basis, and felt that the use of the RAP button, coupled with other future staff wellbeing initiatives would improve matters. Regarding the PPG the provider informed us that they were grateful for the valuable work they had done, but felt there was more work to do to make the group effective. This included improving communication, and tackling key concerns such as access.</p> <p>We saw from PPG minutes that the provider had discussed the need to revise the PPG and that they would return to the PPG with proposals.</p> <p>The provider offered support to medical staff undergoing training, this included GP registrars. At the end of their placements registrars gave their views on the experience at the practice. We saw that feedback had been very positive about the level of support they had received.</p>	

## Continuous improvement and innovation

### There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence:                      The provider had developed a quality improvement programme which included:</p> <ul style="list-style-type: none"> <li>• A clinical audit programme.</li> <li>• Learning and improvement from the analysis and investigation of significant events, other incidents, complaints, and direct feedback.</li> <li>• Adoption of detailed performance management processes.</li> <li>• Restructuring organisational teams to increase capacity and meet the needs of the local population.</li> </ul> <p>We also heard from the provider that they planned to discuss within their PCN, opportunities for collaborative working to enhance education and learning.</p>	

#### Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands. The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

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

The following language is used for showing variation:

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

Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

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

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