

Inspection Evidence Table

Kings Medical Centre

(1-559469498)

Inspection Date: 5 October 2023

Date of data download: 26/09/2023

Overall rating: Good

Context

The practice was located in Essex in an area with a deprivation rating of 10, being in the least deprived areas of the UK. The practice list size was approximately 7810. The practice population had an equal percentage of males to females in their population. The practice was in line with local and national averages for older, working age and young people. The ethnicity of the practice was reportedly 85.8% White, 8.2% Asian, 3.0% Mixed, 2.1% Black and 0.9% other ethnicity.

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial ¹
There was active and appropriate engagement in local safeguarding processes.	Y

The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a clinical lead for safeguarding. Safeguarding policies were in place to support staff. Staff we spoke with were aware of the support available. • There were monthly multidisciplinary team (MDT) meetings in place with external partners. • We saw that safeguarding was a standing item on the weekly practice clinical meeting agenda. • There was a programme in place to ensure that all staff received an appropriate DBS check. • Staff responsible for chaperoning had received appropriate training for this role. Staff we spoke with described their role and responsibility. • ¹During the inspection we saw that not all staff had completed the appropriate level of safeguarding training for their roles. Immediately after the inspection the practice undertook a review of all staff identified and strengthened their system to monitor training for the future. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial ¹
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The provider had a recruitment policy, induction policy for new staff and staff appraisal policy and procedure in place. • ¹We viewed 5 staff files and found that they did not always include all information required. For example, we saw gaps in proof of vaccine immunity status (hepatitis B, rubella, tetanus, MMR, and COVID-19) and of yearly appraisals for clinical staff. We discussed this with the practice manager at the time of our site visit, who confirmed that staff vaccination was based on self-declaration; and all non-clinical staff had received an appropriate appraisal within the last 12 months. Immediately after the inspection the practice undertook a review of their recruitment processes and provided assurances that an action plan had been developed to ensure processes aligned to national and local policies. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: May 2023	Y
There was a fire procedure.	Y

Date of fire risk assessment: January 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Records showed that portable application testing (PAT) and calibration of equipment had been carried out within the last 12 months. We reviewed maintenance records and saw the practice had undertaken fire alarm, fire extinguisher and emergency lighting checks. Fire alarm checks were carried out weekly. There had been a fire evacuation drill in June 2023. Overall, there was oversight of the training and staff were given information when training was due. However, training records showed that two members of staff had not undertaken fire awareness training. Fire wardens had undertaken training for their role. Staff we spoke with were aware of fire exits in the building and the fire assembly point. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y ¹
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: July 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial ²
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> ¹Overall, staff had received up to date training appropriate to their role. We identified one member of staff who had not completed training, there was oversight of the training and staff were given information when training was due. On the day of the inspection, we observed the practice to be clean and tidy. We saw that sharps bins were available in the clinical rooms we viewed. Sharps bins were signed, and date appropriately and not overfilled. There were nominated infection prevention and control (IPC) leads. All staff we spoke with knew who the leads were. ²We were provided evidence of a comprehensive audit and monitoring system for infection prevention and control conducted at the practice. Most actions from the last IPC audit had been completed. The practice had identified areas for improvement, for example sinks within clinical areas were not in line with national guidance best practice. A further audit had been arranged in November 2023 with the local Integrated Care Board (ICB) infection and prevention team to review and provide further guidance. 	

Risks to patients

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

	Y/N/Partial
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There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a system in place to ensure there were enough staff to provide the service. The practice had access to regular locum support for the clinical team. The reception and administrative team consisted of full and part time staff members who were able to cover sickness and absence. Managers described a system in place for ongoing recruitment. • We saw there was an induction policy in place. We reviewed 5 staff files and saw evidence that an appropriate induction had been provided. On the day of the inspection a new cohort of GP trainees were undertaking a scavenger hunt within the local area to assist the trainees in understanding the local area. • The practice was equipped to respond to medical emergencies, and the staff were suitably trained in emergency procedures. • Receptionist were supported with training to identify signs of sepsis, and staff we spoke with described the action they would take in an emergency situation. • The practice was supported by the Primary Care Network through which patients could access clinical care from clinical pharmacists, paramedics, first contact practitioners, health coaches, mental health practitioners, social prescribing link workers, advanced nurse practitioners and paramedics. Managers told us that there were plans for further expansion of these roles. 	

Information to deliver safe care and treatment

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

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

- A review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients. For example, history, examination, management plans, safety netting and follow up details were adequately documented within the patient record.
- The practice had a process in place to ensure new patient paper records were summarised and appropriate information captured on the clinical system. The provider told us they had a small backlog of summarising due to capacity and recruitment. However, there was a filing system in place to ensure all information was easily accessible and they were taking steps to address this.
- The practice had a process in place for managing urgent 2 week wait cancer referrals. There were systems in place to monitor that patients had been offered an appointment with the hospital within 2 weeks. Patients were provided with information explaining the 2 week wait suspected cancer referral process during their consultation.
- There was a process in place for the management of test results. In the event of a requesting GP being absent, there results would be reviewed and actioned by the duty doctor.

Appropriate and safe use of medicines

The practice had 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) (01/07/2022 to 30/06/2023) (NHSBSA)	0.80	1.09	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2022 to 30/06/2023) (NHSBSA)	6.5%	8.1%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	4.68	5.39	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	63.3‰	89.3‰	129.6‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.45	0.42	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	7.1‰	6.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. 1	Y
The practice had a process and clear audit trail for the management of information about changes to a patient’s medicines including changes made by other services.	Y
There was a process for monitoring patients’ health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> • Medicines were stored safely and securely in line with national guidance. • We were informed that the majority of prescriptions were generated via the electronic prescribing service. In addition, the practice had a process in place to ensure blank paper prescriptions were stored securely and usage was monitored. • As part of the inspection our CQC GP specialist advisor (SPA) conducted searches of the practice clinical records system, to assess the processes around medicines management and prescribing. The searches were undertaken remotely without visiting the practice. 	

- During our records searches, we saw evidence of overall good quality, structured medication reviews being carried out by clinical staff. The reviews covered all medications and included a documented discussion around compliance, side effects and checking appropriate monitoring was up to date. We identified 1 patient with an abnormal thyroid function test, a repeat test had not been actioned. The provider took immediate action to address this.
- The searches performed confirmed that processes were in place for monitoring disease modifying anti-rheumatic drugs (DMARDs) and other medicines that required monitoring. The records reviewed showed that most patients were up to date with their monitoring checks with no significant patient safety risks identified. We found that:
- Methotrexate (A drug used to treat inflammatory conditions like rheumatoid arthritis): We identified 26 patients who had been prescribed methotrexate and of those, we identified 3 patients who had potentially not received the required monitoring. We looked at these 3 records in more detail and found 2 patients were being managed within a secondary care setting, and the other 1 patient had the required monitoring. Good practice was noted in 1 patient record and the day of the week on which the patient should take Methotrexate was recorded on the patients' prescription which was recommended in Medicines and Healthcare Regulatory Authority (MHRA) advice from September 2020 to reduce the risk of overdose. However, 1 patient had a prescription issued without shared care arrangements in place, and the medicine was subsequently stopped within secondary care. There had been no harm to the patient. During the inspection the provider took action to ensure learning from potential risk to patients was discussed with clinical staff at the practice.
- We reviewed the number of patients taking a high-risk medicine used to prevent heart rhythm disorders. Our searches indicated that 14 patients out of the 724 prescribed this medicine, had potentially not received the required monitoring. We looked at the 5 records for patients at the practice in more detail and saw that monitoring was in line with national guidance, and that the practice had a system in place to invite patients for review. We identified that 3 patients had been invited for review but had not responded to these requests. During the inspection the provider made amendments to 1 patient record to ensure that the patient's diagnosis was appropriately coded on the system.
- The practice was aware of their prescribing outcomes. The practice had utilised the support of the Primary Care Network (PCN) pharmacists. They engaged with the commissioning Medicines Optimisation Team on prescribing initiatives to ensure safe and effective prescribing.
- The practice held all recommended emergency medicines.
- Vaccine refrigerators were in good working order and there was a record of daily temperature checks carried out.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y

Number of events recorded in last 12 months:	2
Number of events that required action:	2
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was a process in place for reporting and recording incidents. However, we found that in some cases incidents were discussed in clinical meetings, but not recorded on the practice's significant event log. The practice acknowledged that there was a lower number of incidents recorded than expected for a 12-month period and told us they would review their processes to ensure all incidents were recorded, to drive learning and quality improvement. • Staff told us they were aware of the process to report an incident and said they felt confident to do so. 	

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

Event	Specific action taken
<ul style="list-style-type: none"> • A patient was incorrectly prescribed two differing medicines by two differing clinicians for the same issue. 	<ul style="list-style-type: none"> • The root cause of the problem was investigated. • The patient was contacted, and an apology given. • The correct medicine was prescribed. • Learning was shared at a practice team meeting.
<ul style="list-style-type: none"> • A patient was prescribed an incorrect medicine. 	<ul style="list-style-type: none"> • The root cause of the problem was investigated. • The patient was contacted, and an apology given. • The correct medicine was dispensed to the patient. • Staff observations and support undertaken. • Learning was shared at a practice team meeting.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had systems and processes in place to receive, disseminate and act upon alerts received through the Medicine and Healthcare products Regulatory Agency (MHRA) and the Central Alerting System (CAS). • The practice maintained a log of all safety alerts received and action taken. • As part of our inspection, we conducted a series of searches of clinical records to assess the systems and processes for acting on medicine safety alerts. We saw that the management of patient safety alerts was good. For example, we reviewed 5 patients prescribed medicines which may cause birth defects if they are used during pregnancy. We saw that there were no issues with the monitoring of these patients, and all had been informed of the associated risks. 	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">As part of our inspection, CQC's GP specialist advisor (SpA) undertook a number of in-depth searches of the practice clinical records system. We found that care and treatment of patients was delivered in line with current evidence-based practice.Staff told us they knew how to review current evidence-based guidance and we saw that these were shared at clinical meetings.	

Effective care for the practice population

Findings

- Those identified received a full assessment of their physical, mental, and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles, and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice had 16 patients coded with a learning disability, of which 13 had been offered a health check in the last 12 months. Of these, 11 patients had consented to a health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. They had support from Primary Care Network (PCN) employed social prescribers and mental health practitioners.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice supported housebound and vulnerable patients, such as those on palliative care. End of life multidisciplinary meetings were held monthly and attended by GP's, district nurses, palliative care nurses, mental health teams and occupational therapists.

Management of people with long term conditions

Findings

As part of the inspection, a number of clinical records searches of patients with long-term conditions was undertaken by a CQC GP specialist advisor (SpA). Our searches found:

- There were 773 patients with asthma on the practice register. Of these patients we saw 17 had been prescribed 2 or more courses of rescue steroids in the last 12 months. We reviewed 5 patients and found that 4 patients had received an adequate assessment at the time of prescribing rescue steroids. We saw that 1 of these patients had an annual asthma review undertaken in the last 12 months. We identified 3 patients who had not been issued with a steroid card. We identified 1 patient who required immediate review, during our inspection the practice had scheduled an asthma review with this patient.
- There were 323 patients with chronic kidney disease (CKD) on the practice register. We saw that 322 patients with CKD stage 4 or 5 (the most severe stages of the disease) had blood pressure monitoring or urea and electrolytes testing undertaken in the last 18 months, in line with guidance. We identified 1 patient who required immediate review, during our inspection the practice had undertaken action to monitor this patient.
- There were 400 patients with diabetes on the practice's register. We saw there were 6 patients with diabetic retinopathy whose latest HbA1c was more than 74mmol/l. We reviewed 5 patient records and found that appropriate structured diabetic annual reviews and medication reviews had been undertaken in the last 12 months. During our inspection the practice had undertaken action to ensure patients had been recalled for their annual review.
- There were 292 patients with hypothyroidism. We saw there were 288 patients with hypothyroidism who had the required monitoring within the last 18 months. We reviewed the records of 4 patients who had not had the required monitoring and found that 2 patients were likely not to have been administering their medicines as prescribed, due to the low uptake of prescription requests. In addition, we found that there was a missed opportunity to discuss this with 1 patient at their last medication review. We saw

that 1 patient had been prescribed an incorrect dose of medicine to support the condition. During our inspection the practice had reviewed and amended the prescription and action had been taken to share the learning identified with the clinical team.

In addition, we found:

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	77	86	89.5%	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)	83	89	93.3%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	82	89	92.1%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	82	89	92.1%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	83	88	94.3%	Met 90% minimum

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

Any additional evidence or comments

The provider had met 4 out of 5 childhood immunisations national targets. The practice had taken action to increase the immunisation rates for children. The nursing and administrative staff contacted parents and carers of children not brought for booked immunisations appointments, to encourage them to rebook and attend.

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)	56.6%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	75%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (3/31/2023 to 3/31/2023) (UKHSA)	76.3%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	47.6%	46.1%	54.9%	No statistical variation

Any additional evidence or comments

- The practice had processes in place to invite patients for cancer screening appointments. Staff monitored if patient attended. If they did not attend, staff contacted patients to invite them again.
- We saw the practice had information about cancer screening and awareness displayed in the waiting area.
- Staff told us, to improve uptake with cancer screening, data was reviewed on a monthly basis. Additional nurse sessions from June 2023 had been introduced to improve access to cervical cancer screening and childhood immunisations appointments. This provided an additional 40 appointments each month; there had been a review of targeted messaging to patients and care co-ordinators roles had provided administrative support. In addition, the practice was working with the local Primary Care Network (PCN) to identify additional weekend capacity for patients. They planned to focus on identifying and working with the learning disability nurse to ensure patients on the learning disability register, who may require additional support and advice, understood the benefits of the vaccination programme.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The provider shared a range of clinical and non-clinical audits to monitor and improve performance. For example:</p> <ul style="list-style-type: none"> The practice had reviewed the impact of secondary care waiting times, to identify areas to reduce practice workload in referral and appointment follow up. The aim of the quality improvement project was to accomplish a reduction in the amount of time spent engaged in follow up of secondary care appointments and provide a standardise response. As a result of the review the practice had implemented documentary tools to support both staff and patients, for example an information sheet to better signpost patients to secondary care. The practice had carried out an audit in 2023 to identify the monitoring of HbA1c (blood glucose levels) in women with gestational diabetes. The audit had identified 37 eligible patients through a series of clinical searches. The audit identified that 60% of women were being monitored within the first 12 months after delivery, however 75% of patients had not had blood glucose monitoring after the first 12 months of delivery. The audit identified limitations of the clinical searches, for example clinical coding within a patient record, access to blood results within a secondary care setting. The audit had been discussed at a clinical meeting to share actions and learning. 	
Any additional evidence or comments	
<ul style="list-style-type: none"> Staff performed clinical audits to ensure safe and effective care was provided, and non-clinical audits, for example, to monitor IPC, cleaning standards and cold chain. The provider monitored prescribing decisions and quality of referrals, to assess adherence to best practice clinical guidance. The provider benchmarked its own performance against other practices' performance within the PCN. As an accredited teaching practice, we saw that the practice encouraged a culture of learning and development and saw evidence of audits conducted by medical students and General Practice trainees were shared at clinical meetings. The practice participated in General Practice research, working with the Clinical Research Network Primary Care, part of the National Institute of Health and Care Research, participating in improving the health of the nation through research. 	

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.	Partial ¹
The practice had a programme of learning and development.	Y ²
Staff had protected time for learning and development.	Y ²

There was an induction programme for new staff.	Y ³
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 ⁴
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y ⁵
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • ¹ The practice had a mandatory training schedule in place for clinical and non-clinical staff and there were systems in place to monitor when mandatory training updates were due. Where training was overdue, training reminders were sent to staff. • ¹ During our inspections we identified gaps in the completion of mandatory training, and not all staff had undertaken training to the required level. For example, reception staff had not been completed Level 2 safeguarding training. Immediately after the inspection the provider confirmed that all reception staff had completed the required level of training. The provider shared details of an action plan to support alignment of training to national guidance; details of a PCN project to align training across the PCN to ensure consistency and identify areas of priority. In addition, the provider had plans in place to ensure training would be reviewed as part of the annual appraisal programme for all staff. • Staff were encouraged and facilitated to complete all mandatory training identified by the practice. Staff told us they were given protected time to undertake their training or were able to complete training outside of normal working hours when required. • ² Quarterly training focus sessions had been identified to highlight one element of mandatory training. • ³ There was an induction policy for new staff, which included a timetable for induction, and these were role specific. After the inspection the provider confirmed that arrangements had been put in place for managers to have oversight and sign off new starter induction and recruitment checks to ensure compliance. • ⁴ All non-clinical staff had received or had a planned appraisal. We reviewed 5 recruitment files and found that clinical staff had not always received an annual appraisal. Following the inspection, the practice had identified areas for improvement, for example nursing staff appraisals would be aligned to the same timeline as non-clinical staff going forward; and managers had been identified to undertake these appraisals. • The continuing development of staff skills, competence and knowledge were recognised as being integral to ensuring high quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferrable skills, and share best practice. • ⁵ The practice had arrangements in place to provide supervision for PCN employed staff, for example paramedics and pharmacists. • The practice nurse had undertaken professional development to support women experiencing menopause symptoms. 	

Coordinating care and treatment

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

Y/N/Partial

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice told us they worked closely with other organisations to ensure patients received care in a coordinated manner. This included close working relationships with, for example, the local palliative care team and community nursing teams. We saw evidence of meetings with specialist multidisciplinary teams to support patients with long term conditions, such as asthma, COPD or diabetes, or those patients that were palliative and/or vulnerable. 	

Helping patients to live healthier lives

Staff were proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> A range of health checks and reviews were offered for patients, where they were encouraged to be involved in management their own health, for example smoking cessation. The practice encouraged patients to monitor their blood pressure using the practice's in house monitor. The practice provided social prescribing sessions which helped patients improve their health, wellbeing, and social welfare by connecting them to community services. 	

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.	Partial ¹
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Y
<p>Explanation of any answers and additional evidence.</p> <ul style="list-style-type: none"> All staff had completed mental capacity and deprivation of liberty training. ¹ We reviewed 3 records for patients who had a DNACPR in place. We found overall there were clearly documented reasons for the DNACPR decision that were not discriminatory or based on assumptions about the patient's quality of life. Of the 3 records we looked at, 2 did not have evidence to demonstrate a decision regarding mental capacity for these patients. The practice told us they would discuss this with appropriate colleagues at a future clinical meeting, and make sure all DNACPR forms and decision making was clearly documented. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> During the on-site inspection, we observed reception staff talking with patients on the phone and at reception. Staff were respectful and helpful to patients, even when faced with challenging behaviours. 	

Patient feedback	
Source	Feedback
CQC Give Feedback on Care	In the 12 months prior to our inspection period, CQC had received 1 complaint and 12 positive feedback submissions.
Inspection feedback	Patients and relatives who spoke with on the day of inspection were positive about how staff had treated them.
NHS.uk website (formerly NHS Choices)	There were 5 reviews posted on the website in the previous 12 months. Patient feedback was positive. Patients described staff as 'very caring and helpful', 'always ready to listen' and providing a 'five-star service'.

Staff	The staff we spoke with during the inspection commented on the caring nature of the team towards patients.
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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)	89.3%	82.5%	85.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)	92.0%	80.7%	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)	97.1%	91.4%	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)	85.0%	66.5%	71.3%	No statistical variation

Any additional evidence or comments

- The practice performed above England and local averages for the above indicators.

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

Any additional evidence

- The practice carried out a patient survey in December 2022, which asked for feedback on such topics as the practice website, access, including disability access. Managers had analysed the results of this survey. As a result of this survey the practice had identified areas for review, for example to improve the visibility of 'Live well' information to support patients and carers.
- The practice analysed the monthly results for the 'Friends and Family' test.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Easy read and pictorial materials were available. • On the day of the inspection, we heard reception staff speaking with patients in a kind and caring manner. 	

Source	Feedback
Interviews with patients.	Patients we spoke with were very positive about the care they received at the practice.

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)	95.1%	89.5%	90.3%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had access to interpretation services, including British Sign Language, and described examples of how this service had been used to support individuals. 	

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> • 36 carers had been identified which was approximately 0.5% of the patient population.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> • The practice had a designated carers board in the waiting room to support carers, and a designated section on the website. • All carers were coded appropriately within the patient records, to ensure they received appropriate invitation to health checks.

	<ul style="list-style-type: none"> • Carers had access to a social prescriber available within the Primary Care Network (PCN). • The practice offered carers an annual influenza vaccination and an annual health check. • The practice had arranged a carers coffee morning in June 2023 as part of a quality improvement project. The practice had identified and implemented improvements, for example inviting a social prescriber to attend future coffee mornings. Feedback was shared with the Patient Participation Group (PPG).
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> • Bereavement advice leaflets were included with condolence cards sent by the practice to family members.

Privacy and dignity

The practice respected respect patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • On the day of inspection, we observed confidentiality at the reception desk. 	

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

Explanation of any answers and additional evidence:

- The premises had disabled access, and there was a hearing loop available for patients who may be hearing impaired.
- Changing facilities were available within the practice.
- There was access to translation and interpreting services as required.
- We saw that there was information for patients about the Accessible Information Standard on the practice website.

Practice Opening Times

Day	Time
Opening times:	
Monday	8am -1pm and 2pm - 6.30pm
Tuesday	8am -1pm and 2pm - 6.30pm
Wednesday	8am - 1pm
Thursday	8am -1pm and 2pm - 6.30pm
Friday	8am -1pm and 2pm - 6.30pm
Appointments available:	
Monday	8.30am – 11.30am - 2pm – 6pm
Tuesday	8.30am – 11.30am - 2pm – 6pm
Wednesday	8.30am – 11.30am
Thursday	8.30am – 11.30am - 2pm – 6pm
Friday	8.30am – 11.30am - 2pm – 6pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Evening appointment were available between 6.30 and 9.00pm on Tuesday evenings.
- Pre-bookable appointment on Tuesday and Thursday evenings were also available to all patients at additional locations within the area, as the practice was a member of a primary care network (PCN).
- Appointments were available all-day Saturday and Sunday 8am until midday. Patients could access 111 outside of hours and at weekends and bank holidays.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Patients were able to book appointments at the practice, via telephone or online, and these could be booked on the day or in advance. The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs. For example, the practice had moved to a total triage model in July 2023 with each appointment request triaged by a clinician to offer face to face or telephone appointments. Prior to the new system patients were required to call in the morning, or ring back in the afternoon when additional appointments were made available, the new system meant that patients were no longer asked to call back. • We reviewed the appointment system on the day of the inspection and saw that this was responsive. For example, a request for an urgent appointment had been sent to the practice through the online system at -8.11am, this had been triaged at 8.36am and an appointment offered to the patient 10.40am the same day. In addition, we saw that reception staff considered individual needs when offering the most appropriate appointment for each patient. • The provider shared appointment data from 28 August to 24 September 2023, 2,566 appointments had been undertaken, of these 1,561 had been undertaken by a GP, 2,095 were face to face appointments. In addition, 131 appointments had been underutilised by patients not attending their appointment. • Feedback from patients about this provision of service was overall positive. • The provider recognised that certain groups of vulnerable patients for example, those at risk of safeguarding concerns or frail patients, may struggle to access health care, with greater impact in the enhancements made to digital solutions. Staff we spoke with confirmed that patients who were not able to use digital tools would be supported by staff to access the service. • A patient access demand action plan had been implemented and monitored since 2021. The plan had included feedback from the Patient Participation Group (PPG) and identified areas for improvement. For example, feedback in August 2021 had identified difficulties in patients getting through to the surgery by telephone. Since August 2021 the practice had: Introduced a telephone queue system; introduced a call back facility which allowed patients to be held in their queue position and called back by practice staff; recruited additional reception staff providing 20 hours additional support. • The practice had increased the number of face-to-face appointments; introduced online triage which was available from 7.30am until 4.30pm for patients to submit an online request; increased the number 	

of on the day appointments by employing additional roles to support capacity, including paramedic and pharmacist appointments.

- Patients had access to additional appointments at the PCN led clinic hub, this included spirometry, social prescribing and health and wellbeing.
- Additional nurse sessions from June 2023 had been introduced to improve access to cervical cancer screening and childhood immunisations appointments providing an additional 40 appointments each month.
- A cloud-based telephony system was implemented in July 2023, to improve patient experience, aiming for shorter waiting and call times.
- The practice website contained information regarding services delivered at the surgery as well as services delivered by other organisations and promoted self-referral to local services, for example wellbeing and loneliness services within the community.
- Patient who had urgent needs were prioritised.
- Patients who had a learning disability were provided with a longer appointment.
- The practice provided care to two nursing homes within the local area. Feedback from staff we spoke with at one of the care homes was extremely positive.

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)	53.2%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	61.0%	49.4%	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)	62.5%	47.3%	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)	82.7%	68.9%	72.0%	No statistical variation

Any additional evidence or comments

- The practice scored above local and national averages in terms of patient satisfaction related to access and appointments. We saw that this was a positive trend over time. The practice had met to discuss the results of the survey to review their plan to continue to improve access further, for example to continue to explore PCN joint working to co-ordinate flu vaccination, including identifying vulnerable housebound

and care home patients; consider winter capacity planning, commissioner support and continue an engagement campaign with patients.

- The practice newsletter supported patients to access the practice, for example we saw that it highlighted low and high peak call times.

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were 5 reviews posted on the website in the previous 12 months, 4 reviews referred to access. 3 reviews rated the service as 5 stars for access, the other rated the service 2 stars. All of the reviews had been responded to by the practice.
CQC – patient feedback	In the 12 months prior to our inspection period, CQC had received 1 complaint and 12 positive feedback submissions. Themes included response to appointment requests and time taken to discuss concerns.
Inspection feedback	Patients we spoke with on the day provided mixed feedback including positive comments regarding routine appointments and concerns regarding accessing the practice through the new online system.

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.	17
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Concerns regarding reasonable adjustments in place for patient accessing the services of the practice.	Apology provided and patient contacted to discuss reasonable adjustment plan. Internal review completed. Learning shared at clinical meeting. Action taken included: Review of reception process to book appointments directly for patients with reasonable adjustments; review of home visiting service completed and the implementation of bookable home visiting appointments for reception staff to support individual needs. Call back service introduced. Alert added to the patient record to identify patient needs.

Patient not satisfied with the appointment, including communication needs.

Apology given; patient contacted to discuss preferences for future appointments. Feedback provided to external provider.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had an experienced leadership team, who understood the challenges it faced and had taken steps to address these. The leaders at the practice had a shared resolve to deliver good quality care to patients and development of the workforce.• We saw that the clinical and managerial leadership at the practice worked together to provide a consistent and improving service.• The practice had taken a proactive approach to review and improve access for patients, working closely with partnership organisations.• Leaders held senior positions within the local Primary Care Network, which provided oversight of local challenges and improvement plans, for example the management of extended access.• The practice was responsive and proactive to feedback during the inspection process and acted upon our findings and feedback.	

Vision and strategy

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

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

- The practice had a clear vision and strategy. We saw evidence of partner meeting minutes where these were discussed.
- Staff we spoke with told us they felt they understood what the vision meant.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • As an accredited teaching practice, leaders encouraged a culture of learning and development. • Feedback from staff during the inspection overall was positive about working at the practice. However, staff did not always feel that their concerns had been addressed when raised during their appraisals. • We saw that staff wellbeing was considered by the practice, and the practice shared examples of team building. • The practice had access to a Freedom to Speak Up Guardian. Staff were aware of who this was. • Equality and diversity training was part of the mandatory training schedule, and all staff were up to date with this training. 	

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

Source	Feedback
Staff questionnaires	We received feedback from 9 members of the practice team, this was a mix of clinical and non-clinical staff. Words used by staff included caring, respectful and committed.
Staff interviews	<ul style="list-style-type: none"> • Staff we spoke with described both positive and less positive experiences of working together as a team. • We were told practice leaders were kind, approachable and supportive.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Staff had access to policies, procedures and protocols and knew how to access these.• Staff were clear about their roles and knew who to ask within the team for support and advice.• The practice had nominated leads for key areas, such as the safeguarding of adults and children and infection prevention and control. Staff were aware of who the leads were.• The practice had a regular clinical meeting structure.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Risk management systems, including a risk register were in place to monitor risks on a regular basis. Nurse recruitment had been identified as a risk, a priority risk level assigned, and action plan in place to support the future delivery of cervical smears to the patient population.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was clear and accurate oversight data that was discussed at practice meetings. • The practice used data to benchmark their outcomes against other practices in their primary care network (PCN) and primary care community. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice undertook data protection impact assessments to ensure new processes, including digital systems, were implemented safely, and complied with information governance security standards. • The practice information systems had been externally assessed as compliant in meeting standards to prevent cyber-attacks on its systems. • The practice website explained the security needs for patients to use their online service, for example when sending pictures and images. 	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y

The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had an active patient group that met regularly. • Minutes from these meetings were available on the practice website, and included for example information about access, appointments, and patient surveys. 	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> • The feedback we received from 1 member of the PPG was positive regarding the practice. They told us their views were taken into account, and they felt part of the practice. They provided examples of feedback from the PPG which had been listened to.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<ul style="list-style-type: none"> • The practice was a training practice and there were regular training sessions for GP Registrars. There was a programme in place for mentoring and supervision of the registrars. • The practice participated in teaching GP trainees from the local hospital training scheme, part of Health Education England. • The practice participated in GP research participating in improving the health of the nation through research. • We saw evidence of regular clinical meetings with a focus on quality improvement and learning. • A partner at the practice held a leadership role within the primary care network (PCN). This allowed the team to engage with neighbouring practices in current and future initiatives. For example, the practice worked with other practices to provide a combined flu and COVID-19 clinic at the PCN hub clinic delivering a joined-up vaccination program. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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