

Care Quality Commission

Inspection Evidence Table

Leasowe Medical Practice (1-2595139793)

Inspection date: 5 and 6 December 2022

Date of data download: 01 November 2022

Overall rating: Requires Improvement

Overall, the practice is rated as requires improvement because we found that aspects of the service needed to improve, in particular safe and effective care and treatment.

Safe

Rating: Requires improvement

We rated the practice as requires improvement for providing safe services because the provider did not have adequate systems in place:

- Patients prescribed high risk medicines were not always up to date with routine monitoring to ensure it was safe to continue prescribing medicines to them.
- Actions from safety alerts were not always followed and reviewed to follow best practice guidance.
- Assessments and reviews were not always fully documented in the patient record.

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
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

Safeguarding	Y/N/Partial
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> <p>GPs were trained to the appropriate level 3 for safeguarding children and adults. A clinical staff member had not yet achieved the required level of training and this was undertaken on the day of inspection. Non-clinical staff were trained to level 1. We saw evidence at inspection that higher levels (levels 2 and 3) had been included in training profiles and had been implemented with most of the staff having achieved the higher level at the time of inspection. The non-clinical administrative support had attained level 3 training.</p> <p>Registers for vulnerable adults and children were held and alerts were added to patient records to highlight them. We noted on inspection one record did not have the associated alert. This was rectified by staff at the time of inspection and all safeguarding alerted records checked.</p> <p>Staff recruitment records we sampled showed that Disclosure and Barring Service (DBS) checks had been obtained and assessed.</p> <p>The out of hours service were able to access patients records through the patient record system and use of special notes.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We sampled four staff personnel files. These were generally complete and contained the required information.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2022	Y
There was a fire procedure. Date of fire risk assessment: January 2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a fire plan and fire safety procedures were in place. Firefighting equipment was in place and regularly checked and serviced. Fire drills had been undertaken and documented. There was an up to date fire risk assessment.</p> <p>The practice had a named health and safety officer in place.</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.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 16/10/2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The premises and environment appeared clean and tidy.</p> <p>Staff had been provided with training in infection prevention and control. An audit of infection prevention and control practices had been carried out. The audit showed the practice had attained 100% compliance with the standards.</p> <p>Clinical waste was managed appropriately and within guidance.</p> <p>The domestic cupboard was kept locked, tidy and was suitable for its function.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
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	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Concerns had been raised to us that there were insufficient clinical staff to cover the workload, including no access to a female GP at the practice and no onsite GP one day of the week. The provider had taken action to address these concerns and had increased clinical cover with two female GPs working at the practice one day per week each, redeployment of a physician associate to work four days per week and had advertised to employ a full time advanced nurse practitioner (ANP).</p> <p>GP cover on Thursdays was provided remotely by a locum GP with those patients needing to be seen offered face to face appointments at a neighbouring GP practice. Following the inspection, the provider told us they planned to have a GP working on site at the practice one session on Thursdays and an ANP had been redeployed to work five days per week at the practice.</p> <p>In the event of absence, staff covered from within the team. Holidays were planned and locums covered clinical staff in their absence.</p> <p>Staff were trained in signs of sepsis and medical emergencies. They were able to sign post to urgent and emergency services or get help from clinicians as needed for deteriorating patients.</p>	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment. However, patient records were not always fully documented.

	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.	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: Paper patient records were stored safely and securely. Referrals to specialist services were made in a timely manner overall. Safety netting systems of two week wait referrals for suspected cancers were in place to ensure the appointments were made and taken up by patients. Protocols were in place and followed for the management of test results and communication sent from secondary care. We viewed the computer system and noted that at the time of inspection there was minimal backlog and test results/letters were prioritised and dealt with in a timely manner. Review of patient records in relation to the clinical searches identified that care records were not always managed in line with current guidance. For example, some of the clinical record searches we conducted, showed that assessments and reviews, were not always fully documented.	

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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	1.55	1.03	0.82	Significant Variation (negative)
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). (01/07/2021 to 30/06/2022) (NHSBSA)	12.9%	11.0%	8.5%	Tending towards variation (negative)
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 (01/01/2022 to 30/06/2022) (NHSBSA)	6.44	6.21	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	347.2‰	195.6‰	128.0‰	Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	2.69	0.88	0.59	Significant Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	12.8‰	10.2‰	6.8‰	Tending towards variation (negative)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹	No
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The provider was not able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required.</p> <ul style="list-style-type: none"> The provider prescribed a higher than average number of antibacterial items. Pharmacists employed by the Integrated Care Board (ICB) place supported the practice with monitoring and auditing of prescribing practice. Findings of audits were shared with the practice and individual prescribers were identified if variation from good prescribing practice was evident. The provider showed us evidence from the ICB which demonstrated there were no current concerns in prescribing of antibiotics at the practice. Blank prescriptions were found to be stored overnight in printers in clinical rooms. There was a procedure in place to follow which indicated this should not occur. On the day of inspection, the process for safe storage of blank prescriptions was re-issued and announcements sent to all staff across the organisation and practice so that blank prescriptions were kept safe and an audit trail of use in place. <p>As part of this inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice. We found:</p> <p>Not all patients' health and medicines were reviewed prior to issuing of repeat medicines. For example, Lithium;</p> <ul style="list-style-type: none"> 5 patients were prescribed Lithium (a medicine used to treat mood disorders), of these, 2 did not have recent blood monitoring of Lithium results documented on their records and repeat 	

Medicines management

Y/N/Partial

medicine prescriptions were issued without checking their status. The provider told us these patients would be recalled for review.

- The processes for monitoring patients' health in relation to the use of medicines, including high risk, required improvement. Some medicines are considered high risk because the potential side effects mean appropriate blood monitoring is required. This is for medicines such as Lithium, ACE inhibitors and direct acting oral anticoagulation medicines (DOACs) amongst others. Some patients prescribed these medicines had not received appropriate monitoring.
- 234 patients were prescribed ACE inhibitor or Angiotensin II receptor blockers (used to treat high blood pressure). Of these 22 had not attended for the required monitoring in the last 18 months.
- 23 patients were prescribed a potassium sparing diuretic medicine (used to treat heart conditions), 4 had not had the required monitoring.
- We found that patients prescribed some types of anticoagulation therapy – direct acting oral anticoagulants (DOACs), did not always have the required monitoring. (36 were prescribed DOAC, 9 had not had creatinine clearance function monitored as required).
- 1 patient was prescribed metformin (a medicine used to treat diabetes) and was found not to have had the required intervention. This was immediately addressed, and the patient was contacted and had a face to face appointment on the day of inspection.

Whilst we had found concerns with some of the monitoring of patients on high risk medicines, we also found that some had been cared for, monitored and treated appropriately. For example, patients prescribed Azathioprine, Amiodarone and Warfarin:

- Patients prescribed disease modifying anti-rheumatic drug (DMARDs) generally were monitored satisfactorily. For example, out of 9 patients who were prescribed Methotrexate 1 was minimally overdue their monitoring.

We found that the system for coding patients with potential health conditions such as chronic kidney disease and diabetes needed improvement so that patients had access to the health checks they required.

Following discussion with the clinical team around the findings of our clinical searches, the provider told us and showed us evidence which demonstrated they had immediately assessed those patients at risk, had reviewed their records, and acted to review patients health and monitoring where needed. It was identified that oversight systems on the patient record system were not being used to the full potential in order to ensure appropriate monitoring of patients prescribed high risk medicines. The provider gave us a plan of action at the time of inspection to address the concerns found by the searches which addressed actions needed. They had put systems and processes in place to help ensure patients requiring careful monitoring due to their prescribed medicines were monitored as required. We will follow up these actions at the next inspection of the practice.

- The practice had appropriate stocks of emergency medicines and equipment that were stored safely and checked regularly.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, there was under reporting of incidents by staff.

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.	Partial
Number of events recorded in last 12 months:	1
Number of events that required action:	1
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us they knew how to report significant events and incidents. One significant event had been recorded, investigated and actions had been taken in response and to prevent recurrence in the last 12 months.</p> <p>Clinical and non-clinical incidents were also reported and documented. Discussion of significant events and incidents was included as a standing agenda item at practice meetings. However, meetings had not taken place regularly since August 2022. Events and incidents reports were available for staff to review on the electronic system. Plans were in place to reinstate regular staff meetings. Significant events and incidents were monitored quarterly to identify themes and trends.</p>	

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

Event	Specific action taken
Patient commenced on treatment by another provider which caused gastric problems. Practice reviewed the significant event to learn from any mistakes they may have made.	Significant event reviewed in conjunction with other providers care and treatment. Prescribing policy for certain medicines was reviewed and changes made.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The system in place to ensure oversight and governance of safety alerts needed improvement. Staff demonstrated how they received, disseminated and monitored alerts and information relevant to general practice via a health surveillance dashboard. Alerts were assessed for relevance and distributed to staff. However, there was no log in place to monitor these had been actioned and we found that some medicine alerts had been identified as needing action but had not been acted upon in a timely manner. Alerts were not looked at and assessed retrospectively.</p>	

The provider did not demonstrate that all relevant safety alerts had been responded to. Patients remained on combinations of medicines that increased their risk of health problems without anything documented in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered. We examined five patient records we had identified by searches as needing action following an alert and found that these patients prescribed potentially teratogenic medicines had not been informed of the risks and appropriate advice given.

This was brought to the attention of the provider and rectified, with review of patients on medicines alerted, patients contacted, and appointments made. An action plan was implemented during the inspection. We will follow up actions taken at the next inspection.

Effective

Rating: Requires improvement

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.

We rated the practice as requires improvement for providing effective services because: -

- The provider did not have adequate systems in place for the appropriate assessment, monitoring and review of patient's care and treatment.
- Cervical cancer screening was below the 70% target and had been for a number of years.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Partial
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	Partial
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 prioritised care for their most clinically vulnerable patients.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Members of the clinical team we spoke with or received feedback from told us they felt supported in their role and told us how they kept themselves up to date with best practice guidance. Clinicians took responsibility for professional development on an individual basis with support from the provider.</p> <p>We ran a number of clinical searches on the patient record system to look at the care and treatment being provided to a sample of patients. Our findings showed:</p> <p>Patients living with long term conditions were not always managed satisfactorily. For example: -</p>	

- Clinical searches conducted identified 26 patients had been prescribed two or more courses of rescue steroids out of a total number of 177 asthmatic patients. We looked at a sample of five of these patient records and found that they had not been followed up appropriately and some had not been issued with a steroid treatment card. This was rectified at the time of inspection.
- 21 patients prescribed medicines for hypothyroidism were overdue thyroid function tests and review of their medication. This was rectified at the time of inspection.
- 16 patients were identified as having diabetic retinopathy and higher than average blood sugar levels. We looked at a sample of three records and found these did not have full structured reviews of their medicines.

At the time of inspection, the provider showed us and told us about an action plan which would address the concerns found and plans had been put in place to review those patients identified. We will follow this up at the next inspection of the practice.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. 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.
- Patients with a learning disability were offered an annual 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 practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- From our clinical records searches we found some patients with blood test results indicating they may have an undiagnosed long-term condition. This had not been documented in records and therefore they were at risk of not being reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. There were three cases that we looked at of potential missed diagnosis of chronic kidney disease. These were coding errors which could have resulted with the potential of patients not receiving appropriate monitoring. The provider addressed these issues at the time of inspection and put in place an action plan and process for coding.
- Patients prescribed four or more repeat medicines needed a medication review. The provider put action in place to identify and review these patients at the time of inspection.
- Patients with long-term conditions were not always offered an effective annual review to check their health and medicines needs were being met. We looked at a sample of patients diagnosed with

asthma, chronic kidney disease and hypothyroidism and identified that improvements were needed to ensure they received reviews and follow up as per guidance for these conditions.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice did not always share clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. For example, for patients with long term conditions such as hypothyroidism, the practice did not always obtain and document test results from secondary care which could have impacted on their medicines prescribed and on their health.
- 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	38	42	90.5%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	31	33	93.9%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	31	33	93.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	31	33	93.9%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	53	59	89.8%	Below 90% minimum

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

Any additional evidence or comments

The practice was slightly below the minimum target for the indicator for children aged 5 who had received immunization for measles, mumps and rubella. The practice had an action plan in place to improve uptake by operating additional clinics.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	60.1%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	43.9%	60.9%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	51.6%	58.3%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	50.0%	50.1%	55.4%	No statistical variation

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.

Any additional evidence or comments

The practice acknowledged it was continually below the 70% uptake for cervical cancer screening. Initiatives were in place to help increase uptake, for example, promotion campaigns, opportunistic screening and additional practice nurse hours.

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
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

The provider had a planned programme of annual audit. We saw examples of two cycle audits and improvements linked to prescribing practices and other audits undertaken.

Audits included:

- Infection prevention and control and hand washing
- Minor surgery
- Patient access
- Consultation audits
- Management of gout
- Hypertension management
- Cardiovascular disease
- Cancer referral
- Influenza vaccination
- Urinary tract infections

Any additional evidence or comments

The practice was assisted with their prescribing audits by pharmacists from the Primary Care Network (PCN) and from NHS England medicines management team. They produced a dashboard of prescribing practices and trends for the practice. Any variations from good practice were highlighted and addressed with the individual prescriber.

The cancer diagnosis and referral audit undertaken in August 2022 demonstrated staff were appropriately referring patients for suspected cancer which contributed to early diagnosis and better outcomes.

Effective staffing

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

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

We saw evidence of an induction checklist completed for the most recently employed staff that was relevant to their role. We saw annual appraisals had been completed for all staff, however not all took place face to face, staff were offered an opportunity for this to occur, however most staff received written feedback via email.

Staff we spoke with and feedback in staff questionnaires indicated that they felt well supported in their role and appropriately trained.

Staff had their skill and competencies checked on employment and mandatory training was monitored.

The practice did not currently have any non-medical prescribers working at the practice.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was evidence of shared working with members of multi-disciplinary teams, for example with safeguarding concerns, the practice worked with health visitors and social workers where relevant.</p> <p>Patient records were summarised for new patients. The practice used special notes within the patient record system to share important information about patient's needs. Patient records were accessible to external providers such as the extended hours and out of hours service.</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.	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
Explanation of any answers and additional evidence:	

Patients were supported to manage their health and prevent avoidable disease. The practice was proactive and opportunistic in providing health promotion and health prevention care, advice and treatments. They had equipment in reception for patients to check their blood pressure and weight and information about lifestyle choices and health improvement.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
Explanation of any answers and additional evidence Our clinical review of notes where a DNACPR decision was in place identified patients' views had been sought and respected. We saw that information had been shared with relevant agencies.	

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

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am-6.30pm
Tuesday	8am-6.30pm
Wednesday	8am-6.30pm
Thursday	8am-6.30pm
Friday	8am-6.30pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none">• Patients had a named GP who supported them in whatever setting they lived.• The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.• 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.• The practice held a register of patients living in vulnerable circumstances and they were prioritised.• 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 minimize 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> <p>There were a number of ways patients could book appointments. For example, in person, by telephone, online or via eConsult. Appointments offered included telephone consultations, eConsult, face to face and home visits. Pre bookable appointments were available.</p> <p>Patients who were unsuccessful in getting an appointment on successive days were noted and booked as a priority. Patients requesting a same day/urgent appointment were asked to give further detail so that appropriate consultation/appointment could be offered, even when all appointments were taken that day. Children and vulnerable people were prioritised and clinicians consulted when requesting appointments. Patients were offered appointments at another GP practice in the event of an appointment with a clinician not being available that day. The provider could provide additional clinical at the end of every day and offer urgent appointments if required.</p> <p>Patient feedback from the national GP patient survey 2022 indicated a high level of satisfaction (higher than the national and local averages) for access to appointments.</p> <p>Support was in place for making appointments/contacting the practice for vulnerable people and those who face communication barriers, including those digitally excluded. Alerts on a person's record highlighted those who were vulnerable or had an impairment. Interpreters were available for patients whose first language is not English.</p> <p>There were arrangements in place for signposting to other providers and organisations for primary care services such as phlebotomy, podiatry, minor injuries, pharmaceutical, and other local health and wellbeing services.</p> <p>Out of Hours (OOHs) services were available by calling NHS111 and was provided through the Primary Care Network (PCN) Monday – Friday (6.30pm-8am), Saturdays, Sundays and Bank Holidays. Extended hours service was also provided by the PCN.</p>	

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 average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	76.8%	N/A	52.7%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	65.1%	58.3%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	74.5%	59.7%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	83.1%	74.5%	71.9%	No statistical variation

Any additional evidence or comments

Feedback for the survey was positive for access to the practice and appointments.

Listening and learning from concerns and complaints

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

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

	Y/N/Partial
Information about how to complain was readily available.	Y

There was evidence that complaints were used to drive continuous improvement.	Y
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Example(s) of learning from complaints.

Complaint	Specific action taken
Delay in diagnosis with multiple healthcare providers.	Investigated with learning points identified and disseminated. Patient communication documented.

Well-led

Rating: Good

Leadership capacity and capability

Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The provider is a single-handed GP who has other CQC provider registrations. A team of leaders and managers worked across all of the providers associated registered locations. Staff feedback to the provider that they did not feel supported at practice level, in the absence of a practice lead. The provider had acknowledged these concerns, a new practice lead and senior manager had recently been appointed to work from the practice. The provider and senior management took responsibility and accountability for challenges and concerns identified. They responded immediately to concerns found at inspection and acted to implement improvements where needed.	

Vision and strategy

The practice had a clear vision, but it was not always supported by a 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.	Partial
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: There was a mission statement displayed around the practice. Staff knew and could articulate the ethos of the practice. Staff shared the vision and values to provide high-quality primary care treatment to the patient population. Business planning was evident however, staff meetings were lacking and had not taken place regularly. Staff had not been involved in service development or the strategy.	

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> <p>Discussions with staff and feedback we received in CQC feedback forms indicated that staff were happy in their roles and proud to work at the practice. Staff told us they felt they would be supported by senior managers if they raised concerns and gave recent examples of when the provider had listened to their concerns and feedback and had acted.</p> <p>Staff felt positive about the new practice lead appointment and senior management role working at the practice.</p>	

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

Source	Feedback
Staff interviews and feedback forms	<p>Staff told us they were passionate about their work and felt they worked well as a team to put the patient first. Staff told us they 'loved' working at the practice.</p> <p>They told us it was a great supportive team who cared for patients and treated them as they would like their families to be treated.</p> <p>Concerns raised regarding clinical staffing had been listened to and acted on, for example, there was now access to female GP appointments in addition to the male GP.</p>

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.	Partial
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:	
Regular staff meetings had lapsed and not taken place since August 2022. The provider acknowledged this and had reinstated meetings in November for which we saw the records. Meetings notes were available for staff on the intranet and organisations IT system.	
Staff did not always receive feedback from meetings and events where reviews of the quality and safety of services were discussed, and actions implemented.	
There were quality improvement processes embedded which demonstrated improvements to service and care and treatment of patients. These included analysing and acting upon significant events, incidents and complaints and an annual audit programme.	
Plans were in place to manage and improve the uptake of childhood immunisations and cervical cancer screening.	

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.	Partial
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:	

The provider and senior managers responded and acted swiftly during the inspection to manage and mitigate risks to patients where their health and medicines had not been monitored as required. The provider had a governance dashboard in place to provide oversight of risk. The provider was sighted on risks relating to the provision of care and treatment to patients and had taken actions to improve and mitigate risks.

The provider had a range of non-clinical risk assessments in place that were reviewed and acted upon.

An audit programme was in place with demonstrable improvements seen as a result of audits.

There was a business continuity plan in place with action cards available for staff in the practice.

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:	
The CQC Statement of Purpose needed updating to reflect multi-site collaborative working so that patients were able to have face to face appointments at a neighbouring GP practice. The provider told us they would send in the statutory notification and do this straight away.	

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
<p>Explanation of any answers and additional evidence:</p> <p>Leaflets, posters and the practice website contained information regarding patient records and online services.</p> <p>Staff were able to work remotely where applicable and this suited business needs.</p>	

Engagement with patients, the public, staff and external partners

The practice did not fully involve 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.	No
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> <p>The Patient Participation Group (PPG) had disbanded during the pandemic. We saw and were told about plans that demonstrated the practice was actively trying to recruit and develop a new PPG.</p> <p>Staff felt able to contribute views and raise concerns. Staff told us the provider had listened to their concerns and taken their views into account when improving clinical services and practice leadership.</p> <p>The practice reviewed results of the National GP Patient Survey (August 2022) and acted upon them. The practice also reviewed feedback from the NHS Friends and Family Test (FFT), considered and acted on any comments made.</p> <p>The provider worked with the local primary care network (PCN) to support services within the community, for example, the practice had access to the PCN pharmacist.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice supported and encouraged learning, training and development with protected learning time. There was evidence of learning and improvements through significant event and complaints analysis and through audits.</p>	

Examples of continuous learning and improvement
<p>The provider was aware of challenges to the service and across the health and social care landscape. They used technological advances for reaching out to patients in order to improve health outcomes. Although they used digital technology widely, they recognised and identified a proportion of their patients who may be digitally excluded and therefore vulnerable and acted to include them.</p> <p>The provider had implemented a knowledge, communications and governance platform across the organization. A secure site which detailed live data and information to support governance.</p> <p>Senior members of the organisation participated in various published research projects.</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)	≤ -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 SICBL average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a SICBL 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.