

Care Quality Commission

Inspection Evidence Table

Stillmoor House Medical Practice (1-567709579)

Inspection date: 1 March 2022

Date of data download: 08 February 2022

Overall rating: add overall rating here

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.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: When needed the provider carried out risk assessments on staff who did not spend time alone with patients, such as administration staff, to show why a DBS check was not required.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence:	

We reviewed four staff files. Checks had been carried out in line with the regulations.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 16/09/2021	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 16/03/2021 Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The fire assessment showed that training was needed for fire marshals, the provider was able to demonstrate that this had been completed.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 16/09/2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The legionella risk assessment carried out in December 2018 identified that there were no control measures in place, such as checking of water temperatures and flushing out of little used outlets. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings.) The provider told us there were new water tanks, with built in thermometers, which enabled them to identify quickly if the temperature of hot water was out of range. Information from the thermometers was automatically downloaded onto the practice's computer system and reviewed regularly. Checks of cold-water temperatures were made routinely and records were maintained.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes

Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff confirmed they had received training on sepsis and deteriorating patients and had access to guidance on sepsis at reception desks. We saw the guidance during our site visit.</p>	

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Summary care records were accessible from the practice computer system and local care homes were able to use a proxy access system to keep patients' records up to date. Community health care teams were also able to access relevant areas of patient records to update information. The first contact physiotherapist who worked in the practice had full access to patient records and was able to make records of consultations.</p> <p>Electronic discharge summaries were processed by the pharmacy team and clinical coding team and actions were taken when needed. Information from the NHS 111 and out of hours GP services was processed through a workflow system and actioned as needed, urgent tasks were forwarded to the duty GP or pharmacy team when indicated.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.82	0.71	0.71	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). (01/10/2020 to 30/09/2021) (NHSBSA)	5.9%	10.5%	9.8%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2021 to 30/09/2021) (NHSBSA)	5.72	5.34	5.32	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	251.7‰	153.1‰	128.1‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	0.61	0.68	0.63	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	8.7‰	6.8‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice were aware of higher gabapentin prescribing and monitored this to ensure that the medicine was necessary and appropriate for patients' conditions. In addition, there was a recovery plan in place, due to end 31 March 2022 to review patient records and ensure all required recalls for reviews were in place.</p> <p>We carried out searches of clinical records prior to the site visit, to see how the practice managed patients' care and treatment.</p> <p>Results showed:</p> <p>There were 41 patients prescribed methotrexate (a disease modifying medicine) and one had not had the required monitoring. We looked at their record on the site visit and saw they were prescribed this medicine by a hospital consultant and was monitored by the hospital.</p> <p>A total of 86 patients were prescribed warfarin (a medicine used to prevent blood clots), we found six patients had not received the necessary monitoring. A review of the patient record showed that one patient had recently registered at the practice and had been seen to discuss care and treatment. Two patients on warfarin were under the care of the hospital; one patient was monitored in the community and there was an issue with coding the results on their patient record. Of the two remaining patients we</p>	

Medicines management	Y/N/Partial
<p>saw arrangements had been made to carry out a blood test in the community and the other patient had been booked in for a blood test but had not attended. The practice had contacted the patient again to encourage them to attend for the required blood test.</p>	
<p>Our clinical searches identified a total of 15 patients who may have potentially not been diagnosed as having diabetes. A sample of five patient records were looked at in detail.</p> <p>We found:</p> <ul style="list-style-type: none"> • One patient had an appointment booked for a blood test to be taken • One patient consistently declined to have a blood test, but the practice continued to encourage this patient to have appropriate monitoring. • Two patients were on an annual recall system. • One patient had requested the blood test for HbA1c to be carried out yearly, but to this being high previously, as they wanted to monitor their condition and prevent a high result in the future. (HbA1c is a blood test which shows blood sugar levels for the previous three months, and indicates whether these have been stable or not, therefore showing whether a patient's diabetes was well controlled or not.) 	
<p>Patient Group Directives (PGDs) were in use and the practice nurse responsible for ensuring they were in date and appropriately authorised, said they had noted that there were errors with the authorisations. The practice nurse had seen that blank spaces on the form had not been crossed through after being authorised; and additional staff had signed the forms. New copies of all the PGDs used were printed, as some had been updated, and the practice nurse was in the process of getting them signed by staff who used them and authorised.</p>	
Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Yes
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	n/a

Medicines management	Y/N/Partial
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months: 29	Yes
Number of events that required action: 29	Yes

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

Event	Specific action taken
Unexpected death of a patient.	<ul style="list-style-type: none"> The practice had tried to contact the patient but were not successful in speaking with the patient who did not answer calls. The incident was discussed at a clinical meeting and learning identified included that the consultation notes did not state there were failed attempts to contact the patient or details of how they tried to contact the patient. Changes made included three attempts to contact a patient who did not respond. Either by text, mobile phone or a landline telephone on the same day; and a risk assessment to be completed to determine why the patient may not be responding prior to closing off the case. However, the risk assessment did not include whether there needed to be a home visit or the need for police to be made aware to undertake a welfare check. We discussed this with the practice, and they said this would be added to the protocol.

<ul style="list-style-type: none"> • A patient presented with an exacerbation of their long-term condition. • The patient had been using high levels of a painkiller, which were not effective. • All blood tests were normal and screening for cancer was undertaken, with potential to either refer to secondary care, or complete a two week wait referral for specialist cancer treatment. • Blood tests did not identify any concerns; however, the results of the cancer screening were not followed up at the time. • A few months later the screening for cancer was repeated, as it was part of a national programme, and the patient was diagnosed with cancer. 	<ul style="list-style-type: none"> • The practice identified that there was no specific recall system for this particular cancer screening when it was undertaken at the request of the practice. • The patient was also not made aware to contact the practice if results were not received. • The clinician providing care and treatment recognised that they should have identified a time to contact the patient to ensure the test results had been received. • The practice planned to put in a recall system for cases where they suspected a two week wait referral might be needed. This was in the process of being put in place at the time of inspection.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We saw examples of actions taken on recent alerts for example, regarding sodium valproate, a medicine to treat epilepsy, which if used when a woman was pregnant could cause harm to the unborn baby.</p>	

Effective

Rating: Good

QOF requirements were modified by NHS England 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes

Effective care for the practice population

Findings
<ul style="list-style-type: none">• 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. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.• All patients with a learning disability were offered an annual health check.

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

Management of people with long term conditions

Findings

- The practice had a 'month of birth recall' system for the management of patients with long term conditions. There were regular health management clinics for these patients with a mix of appointment types including face-to-face, telephone review, and video consultations to match the needs of the patient.
- Structured medicines reviews were carried out with support from the Primary Care Network pharmacists.
- Monthly meetings were held with the palliative care team to discuss patients under their care.
- The practice held a register of patients with impaired glucose tolerance and recalled these patients for regular monitoring; patients also had access to lifestyle advice regarding the prevention of diabetes and referral available to weight management services was available.

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) (01/04/2019 to 31/03/2020) (NHS England)	97	106	91.5%	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) (01/04/2019 to 31/03/2020) (NHS England)	109	120	90.8%	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) (01/04/2019 to 31/03/2020) (NHS England)	107	120	89.2%	Below 90% minimum

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	108	120	90.0%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	103	123	83.7%	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 were aware of their lower than national average for childhood immunisations and had implemented processes to follow up on children who failed to attend their appointments. This included inviting their health visitor to make contact with the parents. Opportunistic immunisations were offered when possible.

There was a system to identify and follow-up children at risk, with a GP holding bi-monthly safeguarding meetings with the health visitor team to look at families in this group.

There were close working relationships with community midwives and the practice provided clinical support to patients during pregnancy.

Appointments were available outside of school hours and routinely offered evening and alternate Saturday morning surgeries to allow routine access to GP and Nurses at convenient times for parents and children.

The practices operated a joint college-based service which provided lunchtime appointments to pupils aged 13-19 years at the college. These appointments were with either a GP or practice nurse who could make counselling referrals, provide contraception and sexual health advice. Patients did not need to be registered with the practice to access this college based service.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 30/06/2021) (Public Health England)	71.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	46.2%	69.5%	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) (PHE)	66.2%	70.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two	53.2%	54.9%	55.4%	No statistical variation

week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE)				
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Any additional evidence or comments

Cervical screening had been offered throughout the COVID-19 pandemic and the practice encourage women to attend for appointments. The practice offered opportunistic cervical screening and worked with the wider primary care network to offer this service.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

Clinical audits had been undertaken on medicines management, such as a review of all patients on long term antibiotics for urinary tract infections; a review of patients who took steroids to ensure they had an emergency steroid card and their patient records was up to date.
There was a plan in place to risk assess any reviews or monitoring of patients that were overdue, this was due to be completed by the end of March 2022.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff were able to do developmental or training specific to role, such as medical terminology courses and were supported with time and funding to complete this.</p> <p>There was a mandatory training in programme in place, which covered areas such as safeguarding, health and safety and infection control. Recently employed staff said they had undertaken an induction programme. We noted there were gaps in the training log, such as completion of safeguarding training for clinicians being overdue. The provider said staff were reminded via email about training which needed to be completed, staff confirmed this. The practice reviewed completion of training regularly and said that all staff should have completed the training they considered mandatory by the end of March 2022.</p> <p>Staff we interviewed said that it was not easy to undertake mandatory training during working hours and would often complete this in their own time. However, they added that they were able to claim this time back. Staff who were enrolled on external courses, for example role specific training for diabetes, said they had protected time for this training, and were supported with funding by the practice.</p> <p>Non-medical prescribers said they had an annual appraisal with an external person and clinical supervision by a clinical mentor in the practice. Non-medical prescribers were not aware that audits of their work and consultations notes were carried out. We discussed this with the practice who said that they only took action when there were shortfalls and did not share good practice routinely with staff, which did not enable staff to measure whether their performance was safe and effective.</p> <p>There was an appraisal system in place, and the provider had recognised that some appraisals had not been completed, Plans were in place to address this shortfalls. The delay to appraisals being carried out was due to Covid-19 workload, such as the need to administer Covid-19 vaccinations.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>All patients had a named GP and there was space within the appointment system to enable clinicians to book patients in for follow up care to promote continuity of care.</p>	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Consent to care and treatment

The practice 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
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Staff were aware of the consent process, but a minority did not always implement this in practice, such as when an interpreter a family member or friend was used for a patient whose first language was not English. Most staff were able to describe how this would not be appropriate, as they could not guarantee that the correct translation be given by a friend or family member. A minority of staff were unable to describe the consent process they would use for patients who were under the age of 18 years old.All staff who were chaperones had been training for this role and could describe why the role was important to protect both the patient and clinician. If needed a male member of staff was able to act as a chaperone.	

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders were able to demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The practice were in the process of merging with another local GP practice and some staff had started to work at both sites, which had assisted in increasing staff resilience. Consultations had taken place with patients and staff about the proposals and the two practices aimed to merge in July 2022. There were also plans for a purpose built premises, which was being consulted on.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: Staff were aware of the vision and values of the service and said the most important aspect was putting patients first and meeting their needs. Work was progressing on developing a vision and strategy for when the practice merged with another one.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

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

Source	Feedback
Staff interviews	The majority of staff said they had good relationships with their line manager and other managers were visible and approachable. Although, one member of staff did not consider this was how they viewed interactions with managers. We were told that there were systems to enable to concerns or issues to be raised and they had been involved with the merger plans.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: Overall systems and processes were safe and effective. There were minor shortfalls with the complaints process. We found that all written complaints were fully investigated, and a response provided, with an apology if needed. Details of actions taken in response to concerns was documented, put in place and monitored to make sure they were effective. Verbal complaints were emailed to managers, but there was no indication of how this information was used to improve the service where needed. After the inspection, the provider told us they had put a system in place to capture verbal complaints and demonstrate what actions had been taken. We were provided with examples to confirm this.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: The business continuity plan required the details of the Care Quality Commission to be added as an agency who needed to be notified in case of a major incident or business interruption, as specified in the regulations.,.	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: During the COVID-19 pandemic the practice set up an isolation room, which had a separate access from the practice, for patients who were clinically vulnerable, such as those receiving chemotherapy. This was to assist in alleviating the patients' concerns about attending the practice and ensure that the risk of infection was minimised. It enabled patients to have blood tests taken at the practice, rather than having to travel to the local hospital.	

The practice were aware of patients who might be digitally excluded and had made arrangements to support them with accessing care and treatment. Such as homeless patients who were able to register with the practice; and were supported by a social prescriber to access local groups and agencies to meet their needs.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes

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

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.	Yes
Learning was shared effectively and used to make improvements.	Yes

Examples of continuous learning and improvement

The practice continued to work on projects with the primary care network they were part of. Projects included trying to reduce long term cardiac risks for patients with learning disabilities. Another example included for patients with poorly controlled diabetes and a diagnosis of depression, to develop an eight-week programme of healthy diet and lifestyle approaches to assist in patients being able to self manage their conditions.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **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.
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- **%** = per thousand.