

Care Quality Commission

Inspection Evidence Table

The Garden City Practice (1-7457245187)

Inspection date: 15 September 2022

Date of data download: 07 September 2022

Overall rating: Requires Improvement

We rated the practice as Requires Improvement overall because:

- The practices' systems and processes did not always keep people safe and safeguarded from harm.
- Risk assessments were not always supported with a clear record of actions taken.
- The practice's systems for the appropriate and safe use of medicines, including medication reviews required improvement.
- Improvements were needed to the practice's system for recording and acting on safety alerts.
- Patients' needs were assessed, but care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- Improvements in performance related to cervical screening were required.
- Staff did not always have the training and skills to provide care.
- The practice had a vision and strategy that required strengthening to provide high quality sustainable care.
- Governance structures were not always in place. We found gaps for managing risks, issues and performance.
- Systems and processes for learning, continuous quality improvement and innovation, required strengthening.

Safe

Rating: Requires Improvement

At this inspection we rated the practice as requires improvement because:

- The practice did not always provide care in a way that kept patients safe.
- Safeguarding systems, processes and practice required further development.
- Risk assessments were not always supported with a clear record of actions taken.
- Staff did not always have the information they needed to deliver safe care and treatment.
- The system in place to demonstrate the monitoring of non-medical prescribers required improvement.
- The practice's systems for the appropriate and safe use of medicines, including medication reviews, required improvement.
- Improvements were needed to the practice's system for recording and acting on safety alerts.
- Systems to record when things have gone wrong required further embedding.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse, but these required strengthening.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial ¹
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial ²
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a clinical lead and administrative deputy lead for safeguarding and safeguarding policies were in place to support staff. Staff we spoke with were aware of the support available. • Contact information for relevant agencies was displayed within the practice. • ¹ There were gaps in the levels of training for staff appropriate for their roles. For example, we identified one clinical member had not undertaken safeguarding adults and children level 3; current guidance specified all practitioners who have regular contact with patients, their families or carers are expected to undertake Level 3 training. Five non clinical staff members had not completed safeguarding adults training, and an additional eight had not completed safeguarding children's training. Staff confirmed an action plan in place to ensure completion of this identified mandatory training. • ² During the inspection staff provided an example of a recent safeguarding concern and described actions taken, however on review of the patients' medical record a safeguarding alert had not been added to the patient record. 	

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> <ul style="list-style-type: none"> • A recruitment policy was in place which included reasonable adjustments guidance. • We reviewed three staff recruitment files and found gaps in the system. For example, we saw inconsistencies in the system to record that inductions had been completed for both permanent and locum staff. 	

- Information about staff vaccinations was held and staff we spoke with described systems in place to monitor compliance.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 02 March 2022	¹ Partial
There was a fire procedure.	Y
Date of fire risk assessment: 31 May 2019 Actions from fire risk assessment were identified and completed.	² Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹ The provider had undertaken an external health and safety assessment to check that health and safety systems and processes were in place. The assessment had identified eight key areas of focus and key priorities. At the time of the inspection the practice provided assurances that all actions identified had been completed. However, we did not see evidence to support this. Fire evacuation signage was clearly displayed in the practice and staff were aware of the fire evacuation procedure. ² A fire risk assessment had been completed on 31 May 2019 which identified one medium priority action. At the time of the inspection the practice was unable to provide evidence that all actions identified had been completed. Staff told us there had been a delay in undertaking a further fire risk assessment during the COVID-19 pandemic. We identified one member of staff who had not been trained in fire safety, involving how to raise the alarm and what actions to take on hearing the fire alarm. Staff confirmed an action plan in place to ensure completion of this identified mandatory training. Staff we spoke with were able to signpost to the fire assembly point. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	¹ Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 13 September 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found the premises during our site visit of the practice visibly clean and tidy. There was an infection prevention and control (IPC) lead for the practice and IPC policies were in place to support staff. ¹ The practice had identified that all staff should receive Infection Prevention and Control (IPC) training on an annual basis to ensure they were up to date with current guidance. However, we 	

found four members of staff had not completed training. During the inspection the practice provided assurances of an action plan and future monitoring.

- Staff were able to tell us about actions that had been completed in response to their latest IPC audits.
- Reception staff we spoke with understood and were able to explain the process for safely handling clinical specimens.

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y

Explanation of any answers and additional evidence:

- Staff told us that their workloads were manageable, and they worked together to provide support, however capacity did not allow for staff to cover annual leave and periods of sickness.
- The practice had access to Winter Access Funding through commissioners in previous years, but at the time of the inspection agreements from 2022/2023 were still awaited.
- There were arrangements to manage appointments and staff confirmed that when all appointments had been filled requests for urgent appointments were triaged by a clinician.
- Staff knew where to find the emergency equipment, when needed and staff told us that if they had any concerns about a patient, they would speak to a doctor.
- The practice had increased capacity when required through the use of locum GP cover. The practice had access to long term locum GP cover for consistency.

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. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial ¹
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial ²
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Review of patient records in relation to the clinical searches identified that care records were generally managed in line with current guidance. • ¹Regular checks were in place to ensure documentation was processed in a timely manner. On the day of the inspection we identified 964 letters were awaiting allocation to a GP. The oldest letter was dated 26/08/2022. Staff confirmed that urgent correspondence was dealt with on the day and they were aware of the backlog which had been occurred due to staff leave. • ²There were systems in place for referring patients requiring treatment within an urgent two week wait pathway. However, the practice told us that there had been two instances when patients had not been referred within the urgent two week wait pathway. Patients were advised to contact the practice if they had not received information from the secondary care provider, placing the onus on the patient. Following the inspection, the practice had reviewed and revised their system. • All test results were reviewed by a GP, and staff described a system in place when staff were on leave. The practice had safe systems in place to ensure urgent blood tests were escalated for action. We reviewed the clinical system and found no unfiled blood results older than one week waiting to be actioned. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization but these require strengthening.

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	1.07	0.88	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	8.8%	8.6%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.46	5.39	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	93.3‰	94.4‰	128.0‰	No statistical variation
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)	0.57	0.51	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.9‰	5.5‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial ¹
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	Partial ²
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
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	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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
<ul style="list-style-type: none"> Nationally reported prescribing data showed that prescribing was in line with local and national averages. We saw that prescribing policies and protocols were in place and had been reviewed, for example the practice had in place a protocol for safety netting patients on repeat high risk medicines. ¹We saw limited evidence of a system in place to monitor the competencies of non-medical prescribers. Staff told us non-medical prescribers had access to a lead GP for support and met regularly to review clinical competencies. The practice confirmed that they did not routinely record the meetings and were unable to provide evidence of this during the inspection. This was recognised by the practice as an area for improvement. ²Our clinical searches showed that medication reviews did not always include a review of all the medicines prescribed to patients. This meant that not all patients' needs were fully assessed. We saw that the practice had a repeat prescribing policy in place and had implemented a plan to ensure that reviews considered all medications in the future. Staff told us that the Primary Care Network (PCN) had identified the need for an education supervisor to support the clinical pharmacy teams locally. 	

Medicines management**Y/N/Partial**

- We found medicines, vaccines and prescription stationery were appropriately stored and monitored during our onsite visit. Emergency equipment and emergency medicines were available in the practice including medical oxygen and an automatic external defibrillator (AED). However, oxygen was stored in a room without the appropriate hazard signage, staff we spoke with confirmed that signage had been ordered.
- Staff we spoke with understood the importance of maintaining the cold chain for vaccines and were able to explain the process for receiving delivery and monitoring vaccination fridge temperatures.
- Records showed regular monitoring of fridge temperatures was in place to ensure vaccines were stored appropriately to maintain their effectiveness.
- As part of our inspection we reviewed the management of patients on a Disease-modifying antirheumatic drugs (DMARD), medicines used to treat autoimmune conditions. These medicines require routine monitoring and blood tests due to the risk of significant side effects. We found appropriate monitoring in place for the majority of the patients records we reviewed. However, we did not see evidence of shared care protocols or agreements in place or links to these protocols in the medical reviews that had been undertaken. During the inspection the practice had taken action to provide assurances.
- We reviewed a random sample of five clinical records for patients taking a medicine used as a mood stabiliser in patients with mental health disorders. These showed that all five patients had received appropriate monitoring.
- We identified 86 patient prescribed medicines used to treat anxiety that is severe, disabling or causing the patient unacceptable distress. We reviewed a random sample of five clinical records and found that prescription wording was not always clear; two out of five patients had not had a medication review in the preceding twelve months; when a medicine review had been undertaken we did not see evidence of a strategy in place and discussion with the patient to consider a reduction in dosage. Signs of psychological and physical dependence can develop if prescribed for longer periods. During the inspection the practice provided assurances that this had been identified as an area of focus and improvement at a practice level and within the Primary Care Network (PCN).
- We identified 131 patient prescribed medicines used to treat neuropathic pain and occasionally for epilepsy and found 44 patients had not been reviewed within the recommended timescales. We reviewed a random sample of five clinical records and found no active management of these patients and no evidence of the dosage of medicine discussed with patients. In April 2019 these medicines became a Schedule 3 controlled drug and therefore there must be a defined dosing instruction and prescription forms should only be valid for 28 days. During the inspection to practice provided assurances that this had been identified as an area of focus and improvement at a practice level and within the Primary Care Network (PCN) and had taken action to ensure no further prescriptions had been issued for the identified patients.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	27
Number of events that required action:	13
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was an incident management policy in place. • Staff we spoke with were aware of the systems and processes for reporting incidents and were able to share examples with us. • We saw that incidents were a standing agenda item at staff meetings for discussion and sharing learning, however • The practice had implemented a Duty of Candour policy during the inspection and had identified training for staff, we were not able to see that this process was fully embedded within the practice at the time of the inspection. 	

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

Event	Specific action taken
Delay in referral to secondary care	Review completed, incident reported to secondary care provider. Process reviewed and learning shared with all staff.
Repeat medicines request taken by telephone	Review completed, discussed at staff meeting and staff reminded that no telephone request to be taken by reception staff. Phone message reinstated for patients as a reminder that medicines request cannot be taken over the phone. Monitoring calls audit undertaken.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw evidence of actions taken on recent alerts. However, the provider was unable to demonstrate that all relevant safety alerts had been responded to. We saw that 38 patients were prescribed a medicine to patients in childbearing age associated with a significant risk of birth defect and development disorders. We reviewed five random medical records and could not see evidence that the practice had systematically identified patients in childbearing age and informed 	

them of the risks. During the inspection the practice provided assurances that these patients had been contacted to inform them of the associated risks.

- The practice had identified members of staff to coordinate alerts centrally and there was a system in place to share information with staff.

Effective

Rating: Requires Improvement

- Patients' needs were assessed, but care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- Improvements in performance related to cervical screening were required.
- The practices programme of quality improvements and effectiveness required strengthening.
- Staff did not always have the training and skills to provide care.

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

Effective needs assessment, care and treatment

Patients' needs, and care and treatment were overall 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	¹ Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw that clinical meetings were held regularly at the practice. The practice engaged in annual meetings with Consultants in secondary care. • Staff had access to evidenced-based guidance including those from the National Institute for Health and Care Excellence (NICE). 	

- Medicines reviews did not always review all the medications prescribed to patients. This meant that not all patients' needs were fully assessed. During the inspection the practice had implemented a plan to ensure that reviews considered all medications in the future.
- The practice made use of clinical system templates to support the management of patient care and treatment.
- The practice ensured reasonable adjustments were considered to support patient care.
- The practice had adopted its triage system during the COVID-19 pandemic and had reverted to offer patients a choice of appointment options as soon as it was safe to do so.

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. 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

As part of our inspection, a series of patient clinical record searches were undertaken by a CQC GP specialist advisor. The records of patient with long term conditions were checked to ensure the required assessment and reviews were taking place. These searches were visible to the practice.

- Most patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- GPs did not always follow up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. We reviewed five patient records for the care

of asthma who had required a high dose steroid treatment for a severe asthma episode. Records showed that three patients had been issued steroid treatment following a telephone assessment and the documentation within the record was not in line with the prescribed treatment provided. In three of the records we could not see evidence of regular asthma reviews. During the inspection the practice provided evidence of an action plan to address these issues and confirmed that patients had been offered a choice of appointments, including extended access.

- One search reviewed the monitoring of patient with chronic kidney disease. The search identified 17 patients who were coded as having this diagnosis and records showed four patients who did not appear to have had the monitoring in line with national guidance. A review of these records showed three patients were being monitored in secondary care. We saw that one patient appeared to have been lost to follow up as a code to identify the patient had not been added to the clinical record. During the inspection the practice provided assurances of an action plan and future monitoring.
- We reviewed the monitoring of patients with hypothyroidism. The search identified 381 patients coded as having this diagnosis and records shows 30 patients who did not appear to have had monitoring in line with national guidance. On review of five records we saw that three patients were receiving regular care from secondary care, one patient appeared to have been lost to follow up and one patient had refused to undertake the required monitoring. The quality of the medication reviews was discussed with clinicians during the inspection as an area for improvement. During the inspection the practice provided assurances of an action plan and future monitoring.
- A further search reviewed the recording of patients diagnosed with diabetic retinopathy; a complication of diabetes caused by high blood sugar levels. Our search identified that of 527 patients, 55 had high blood sugar levels at the last blood test. We reviewed five patients records and saw that all patients had been reviewed within the last 12 months.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	167	173	96.5%	Met 95% WHO based target

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)	147	154	95.5%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	147	154	95.5%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	146	154	94.8%	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)	167	174	96.0%	Met 95% WHO based target

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 had met performance targets for all childhood immunization. Those who failed to attend were followed up by telephone and letter. Throughout the COVID019 pandemic, patient had access to childhood immunisations service at the practice.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	77.1%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	65.5%	63.6%	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)	71.6%	70.6%	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)	48.1%	55.2%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
<ul style="list-style-type: none"> Uptake of cervical screening was below the 80% national target. Data trends showed uptake had remained consistently below the national target. During the inspection, the practice confirmed that performance relating to the uptake of cervical screening was monitored through the Quality and Outcomes Framework (QOF). QOF data differs to the Public Health England (PHE) data in that it takes into account exceptions, whereas the PHE shows the actual numbers screened. The practice demonstrated recall systems for those eligible for cervical screening. Patients who failed to attend were contacted by telephone. The practice continued to provide access to cervical screening during the COVID-19 pandemic. The practice had identified a member of staff to actively target patients for recall. We saw information to raise awareness of the importance of cervical screening was available in the practice.

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, but this required strengthening.

	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.	¹ Partial
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

<p>The practice shared with us some of the clinical audits that had undertaken, these included:</p> <ul style="list-style-type: none"> • A Primary Care Network (PCN) learning disability audit and improvement plan was undertaken between April 2021 to June 2022. The audit reviewed patients admitted to hospital; highlighted the importance of patients with learning disabilities being vaccinated and identified additional staff support to assist with the referral process. The audit identified six areas for improvement. • A musculoskeletal referral audit was undertaken in November 2021. The aims of the audit were to review the practice referral letter and identify any gaps in information. The practice worked closely with an expert physiotherapy clinician at Hertfordshire Community Musculoskeletal triage team. A teaching session had been held at the practice to increase awareness of the Musculoskeletal triage service, how they work and how to improve referral letters. • ¹ Clinical audit activities were limited to one cycle only. This meant that the provider was unable to demonstrate improvement in quality and safety as a result of audit activity.
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Any additional evidence or comments

The practice confirmed that audit activity had been predominately completed by Specialty Registrars in training previously assigned to the practice. The practice had recently employed two clinical pharmacists and plans were in place for these members of staff to assist in a programme of targeted quality improvement activity.

Effective staffing

The staff working at the practice did not always have the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial ¹
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Partial ²
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.	Partial ³
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> ¹ A training policy was in place for all staff, the policy confirmed that a review of training would be undertaken quarterly and annually. During the inspection we identified gaps in mandatory training for staff, for example we identified seven members of staff who had not completed information governance training, five clinical members of staff had not completed training related to the Mental Capacity Act and eight members of non-clinical staff had not completed equality and diversity training. During the inspection the practice took steps to review the training requirements of all staff and confirmed that the outstanding training would be prioritised. ² Non clinical staff were offered protected time to complete training requirements. However, not all staff were aware of this opportunity. There were systems in place to record the range of skills provided by staff at the practice, including cervical screening, diabetes, chronic health conditions and spirometry. ³ Not all staff we spoke with had an annual appraisal during the COVID-19 pandemic. However, staff had been offered regular meetings and the practice had an open-door policy for staff to discuss any concerns or development opportunities. The Practice Manager had been in place since February 2021 and had recognised this as an area for improvement. 	

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

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had access to a social prescriber who helped patients improve their health, wellbeing and social welfare by connecting them to community services. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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
<p>Explanation of any answers and additional evidence</p> <ul style="list-style-type: none"> Our clinical review of notes where a DNACPR decision had been recorded, this identified where possible the patient's views had been sought and respected, we saw that information had been shared with relevant agencies. Clinicians we spoke with understood the requirements of legislation and guidance when considering consent and decision making. At the time of the inspection the practice was in the process of transitioning towards the ReSPECT system. The process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. 	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff we spoke with demonstrated the values of the practice and dealt with patients with kindness, respect and compassion. We spoke with two members of the Patient Participation Group. Overall, the members were positive about the practice and the care they received. The Patient Participation Group were working together on the relaunch of the group and the recruitment of new members. 	

Patient feedback	
Source	Feedback
NHS UK	We reviewed all of the reviews received in the last year (five reviews). One review was rated with a one-star rating and another with a two-star rating. These reviews were negative about the telephone system used by the practice. This included, long waiting times to get through to a staff member, been cut off by the telephone system, with non-emergency appointments gone by the time you got through to a staff member. However, three reviews were rated with five stars and described staff overall, as caring, compassionate and professional. The practice had responded to all of the reviews they had been alerted to.
Patient interview	Patient we spoke with told us that they were happy with the service they received. They thought that all staff did an amazing job.
Patient interview	Patient we spoke with told us that they had had problems registering with the practice through the online registration form on their website. Patient said that this had delayed the process for booking an appointment.
Patient Participation Group/Patients	Patient Participation Group member we spoke with told us that reception staff were very patient and treated you like if you were the only caller. Patient described them as compassionate people and that reception staff still made you feel as if they really wanted to help you even, if you were the 60th caller.

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	85.9%	84.3%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	89.4%	83.0%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	94.7%	93.2%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	77.5%	70.3%	72.4%	No statistical variation

Any additional evidence or comments

National GP Patient survey results were in line with local and England averages.

Question

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

Y/N

Y

Any additional evidence

- The practice told us that they were currently analysing the recent GP Patient Survey data and working with the Patient Participation Group on a new survey and the relaunch of the group.
- The practice worked closely with the Primary Care Network to monitor patient access plans.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff we spoke with gave us examples as to how they supported patients to understand their care. For example, through the use of easy read and pictorial materials for people with a learning disability. Staff we spoke with also talked about how they referred patients to social prescribers. They can help patients and their carers with further information and access to community and advocacy services. Staff said that this can include benefits and housing support. Patients' waiting areas and clinical rooms were located on the ground floor of the building. There are two waiting areas for patients: bluebell and daffodil. Each waiting area had a wallpaper of the corresponding flowers. Seats had been colour coded in purple and green respectively. The practice used a colour coded system for the clinical rooms. This colour system was clearly displayed inside and outside the rooms. A notice board in the waiting areas tells patients what clinician is working from what room. Staff told us that clinical staff always work from the same room. They also said that patients are called into the rooms by the clinical staff they are visiting. 	

Source	Feedback
Patient interview	Patient told us that having a named GP had supported communications and the continuity of their care.

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	92.7%	90.2%	89.9%	No statistical variation

Any additional evidence or comments

National GP Patient survey results were in line with local and England averages.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff we spoke with gave us examples as to how they supported patients who people who don't speak English as their first language. For example, through the use of interpreters and a staff member who is bilingual. • We saw that there was patient information in the waiting areas in the form of leaflets and through the rolling television screen. • Leaders told us that they had a plan to increase patient information in the waiting areas. • Information about support groups was available on the practice website. • Staff we spoke with told us that patient information leaflets were available in other languages and in easy read formats, if requested by patients. We saw an example of an easy read and pictorial letter that the practice used for people with a learning disability, and a pictorial NHS flu vaccination poster. 	

Carers	Narrative
Percentage and number of carers identified.	518/4.4 %
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> • Carers Champion • Carers information pack • Seasonal vaccines, Covid • Offer of support • Social prescriber • Carers register
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> • GPs contacted families following a bereavement to offer condolences and support • Signposted to practice website for resources and link to National Bereavement Service website • Social prescriber

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

- Staff we spoke with gave us examples as to how they respected patients' privacy and dignity. For example, a room was always available if patients required a private area to discuss sensitive issues. Staff also told us that patients could use a notebook to write down messages and pass it to the receptionist in a confidential manner.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff we spoke with told us that they developed services in response to the needs of patients. For example, the practice offered a range of appointments on the day and pre-bookable. Patients could request a telephone call, a video consultation, a face-to-face appointment or submit an online consultation called eConsult, via the practice website. • The facilities and premises were appropriate and reasonable adjustments had been considered in the design of the interior of the building. • Staff we spoke with gave us examples of reasonable adjustments when patients found it hard to access services. For example, Deaf people or people who are hard of hearing were offered texting to support communications, eConsult service and face to face appointments, with longer time allocated if needed. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am to 6.30pm
Tuesday	8.30am to 6.30pm
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 6.30pm
Friday	8.30am to 6.30pm
Appointments available:	
Monday	8.30am to 6.30pm
Tuesday	8.30am to 6.30pm
Wednesday	8.30am to 6.30pm
Thursday	8.30am to 6.30pm
Friday	8.30am to 6.30pm

- Patients were able to access extended GP services between 6.30-8.00pm Mondays to Fridays and between 8.00am to 4.00pm on Saturdays and from 8.00am to 12.00pm on Sundays.
- Practice opening times, details of clinics and information about extended GP services were available on the practice's website.

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older people 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.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of people with a learning disability.
- The practice adjusted the delivery of its services to meet the needs of people with mental health needs.
- Patients had access to an external home visiting service.

Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	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	Y
Patients with most urgent needs had their care and treatment prioritised	Y

There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice told us that they had kept the doors open throughout the COVID-19 pandemic. • The practice told us how throughout the COVID-19 pandemic they had had a dedicated room for patients with suspected COVID-19. This room was accessible by a separate external entrance. • The practice told us that they had targeted populations for COVID-19 vaccination programmes. • Patients were offered appointments with a range of professionals depending on their needs. • A range of appointments were offered to patients. They were able to choose which they preferred. • The practice offered a variety of clinics, which included, asthma and diabetes. 	

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	32.0%	N/A	52.7%	Variation (negative)
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)	58.9%	52.2%	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)	57.5%	50.6%	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)	75.2%	70.2%	71.9%	No statistical variation

Any additional evidence or comments

- National GP Patient survey results were in line with local and England averages. However, 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 was below local and England averages.
- Staff we spoke with told us that they were aware that some patients had struggled to access the practice through the telephone. They said that to try to reduce waiting times for patients during busy periods, incoming calls were monitored, and all available reception staff answered calls.

Source	Feedback
NHS UK	We reviewed all of the reviews received in the last year (five reviews). One review was rated with a one-star rating and another with a two-star rating. These reviews were negative about the telephone system used by the practice. This included, long waiting times to get through to a staff member, been cut off by the telephone system, with non-emergency appointments gone by the time you got through to a staff member. However, three reviews were rated with five stars and described staff overall, as caring, compassionate and professional. The practice had responded to all of the reviews they had been alerted to..

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.	18
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Information about how to make a complaint or raise concerns was available to patients. • We saw evidence that complaints were handling in a timely way, learning was shared with staff when identified. • All complaints were reviewed by a clinician. • The practice informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint. • The practice had a complaint policy and procedures in place which were available and easily accessible to staff. • Complaints were discussed at the practice meetings and any trends and learning identified. • Informal complaints were noted and actioned. • Positive feedback received by the practice was shared with staff. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient experienced delay in allocated appointment time and expected examination was not carried out. Patient described clinician as having a lack of	Apology and follow up appointment arranged. This appointment included examination requested by patient and discussion of medication needs. Investigation completed and shared with staff.

compassion and not prescribing medication, as expected.	
Patient experienced gaps in referral process and difficulties with telephone access.	Apology and explanation of referral process given, investigation completed and shared with staff.

Well-led

Rating: Requires Improvement

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

- The practice had a vision and strategy that required strengthening to provide high quality sustainable care.
- Staff did not have access to an external Freedom to Speak up Guardian.
- Governance structures were not always in place. We found gaps for managing risks, issues and performance.
- Systems and processes for learning, continuous improvement and innovation, required strengthening.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had continued to provide services to patients during the pandemic and had been agile with policies and procedures in line with national guidance. • The practice was responsive and proactive to feedback during the inspection process and acted immediately upon findings. For example, patients identified as part of our clinical search for further management were immediately reviewed. • Staff we spoke with told us the leadership of the practice (both clinical and managerial) were very visible and approachable. 	

Vision and strategy

The practice had a vision and strategy that required strengthening to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	¹ Partial
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	

- The practice ethos was ‘to strive towards a partnership between patients and health professionals based on the following key facets: mutual respect, holistic care, continuity of care and the therapeutic relationship and learning and teaching’.
- ¹ Not all staff we spoke with knew and understood the vision, values and strategy. The practice had recognised this gap and an away day had been planned to address this area.

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.	¹ Partial
Staff had undertaken equality and diversity training.	² Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff were positive about the culture of the practice. Staff felt able to raise concerns or feedback and told us that there was a no blame culture and strong emphasis on staff wellbeing. • ¹ The practice had a whistleblowing policy in place. Leaders told us that a Partner makes themselves available for staff to speak to in private about any concerns. Managers also had an open door policy. However, staff confirmed that access to an external Freedom to Speak up Guardian required updating. Leaders had identified this as an area for improvement. • ² During the inspection, we found gaps in equality and diversity staff training. Training records provided by the practice demonstrated one non clinical staff member had completed this training in September 2022. All other non clinical staff training was either completed in 2018 or had not been completed. Leaders told us that all staff who had not completed this training would do so by the end of October 2022. 	

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

Source	Feedback
Staff feedback	We spoke with staff during the inspection and received feedback through staff questionnaires. Staff described a lovely atmosphere while working at the practice. Staff felt supported by leaders and able to raise concerns.

Governance arrangements

There were not always 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Governance structures and systems were in place. However, we found that these structures and systems were not effective. For example, we found gaps in staff mandatory training and appraisals, risk assessments and system for managing patient safety alerts. 	

Managing risks, issues and performance

The practice did have processes for managing risks, issues and performance. However, these required strengthening.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial ¹
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial ²
There were effective arrangements for identifying, managing and mitigating risks.	Partial ³
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹During the inspection, we found gaps in the assurance systems. For example, we saw limited evidence of completed risk assessment action plans and that these were regularly reviewed and improved. ²The practice undertook some quality improvement. However, clinical audit activities were limited to one cycle only. Leaders identified a targeted programme of quality improvement to measure outcomes and care and treatment in place that required strengthening. In addition, its effectiveness could not always be measured. ³The practice did not have a risk register in place and we found several areas of risk which had not been monitored or managed. During the inspections, leaders had started to take action to address this. ³The practice's systems for the appropriate and safe use of medicines, including medication reviews, required improvement. 	

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

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The leadership team undertook reviews of practice performance against Quality Outcomes Framework (QOF).. 	

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Staff we spoke with were aware of relevant information governance, data protection and confidentiality procedures. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Feedback from Patient Participation Group.

Feedback
We spoke with two members of the Patient Participation Group. Overall, the members were positive about the practice and the care they received. The Patient Participation Group were working together with the practice on the relaunch of the group and the recruitment of new members.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation. However, this required strengthening.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We saw evidence of staff learning and development, both internally and externally. For example, the practice had an identified mental health lead who had undertaken external learning to assist in the delivery of its services to meet the needs of people with mental health needs. However, we found gaps in the system to monitor mandatory training for staff. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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