# Care Quality Commission

## Inspection Evidence Table

## Holderness Health (1-567948320)

**Inspection date: 17th – 19th October 2022**

**Date of data download: 14 October 2022**

# Overall rating: Good

# Safe Rating: Good

**Safety systems and processes**

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

| Safeguarding | Y/N/Partial |
|---|---|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y |
| Partners and staff were trained to appropriate levels for their role. | Y |
| There was active and appropriate engagement in local safeguarding processes. | Y |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | Y |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Y |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Y |

Explanation of any answers and additional evidence:

- The practices staff training matrix showed that staff had received the appropriate level of training. The matrix was used to identify where staff required further training.
- The practice had regular safeguarding meetings.

| 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 |
| Explanation of any answers and additional evidence:<br>• We looked at 5 different staff files, this included a practice nurse, a GP, a dispensary assistant and 2 members of administration staff. All appropriate recruitment checks had taken place. | |

| Safety systems and records | Y/N/Partial |
|---|---|
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: 18/08/2022 | Y |
| There was a fire procedure. | Y |
| Date of fire risk assessment: Between 30/05/2022 – 26/07/2022<br>Actions from fire risk assessment were identified and completed. | Y |
| Explanation of any answers and additional evidence:<br>• All sites had completed a fire risk assessment between 30/05/2022 and 26/07/2022 | |

**Infection prevention and control**

## Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|---|
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit: 11/10/2022 | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |

**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:

- The organisation had identified a recruitment issue and they regularly reviewed this. They found it difficult to recruit for roles within the dispensary as staff with the required qualifications were difficult to find.
- The practice was embedding a culture of “grow your own staff” through training and upskilling current members of staff. This was done throughout the organisation. The practice trained new registrars who they would then employ as a salaried GP before offering them the chance to become a partner within the organisation. They offered healthcare staff to train to be nurse associates with the aim of them becoming practice nurses in the future.
- The organisation identified an issue with recruiting qualified dispensers, they recently recruited 2 new trainee dispensers so they could train them to become dispensers in the future. In order to assist with the current staffing pressures in the dispensary they had created the new role of dispensary assistant. This role allowed a member of staff to assist with administration work and alleviate some of the pressures faced by the dispensers.

**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. | Y |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Y |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Y |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Y |

Explanation of any answers and additional evidence:

- A review of patient records in relation to the clinical searches we carried out identified that care records were managed in line with current guidance.

**Appropriate and safe use of medicines**

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

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

| Indicator | Practice | SICBL average | England 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) | 0.95 | 0.85 | 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) | 4.2% | 4.5% | 8.5% | 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 (01/01/2022 to 30/06/2022) (NHSBSA) | 4.83 | 5.45 | 5.31 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 149.5‰ | 129.9‰ | 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) | 0.53 | 0.53 | 0.59 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 5.5‰ | 5.6‰ | 6.8‰ | No statistical variation |

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

| Medicines management | Y/N/Partial |
|---|---|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Y |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Y |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Y |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. [1] | Y |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Y |

| Medicines management | Y/N/Partial |
|---|---|
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.[2] | Y |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | Y |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Y |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective. | Y |

Explanation of any answers and additional evidence, including from clinical searches.

- The practice had appropriate emergency medication at all sites. The same medication was available at all sites to ensure consistency.
- Our clinical searches of patients prescribed a high risk medicine indicated that 13 patients aged 65 or older were prescribed a high dose of citalopram or escitalopram. We looked in detail at 5 patient records. All 5 patient records showed that there had been a discussion with the patient about the risks associated with taking both of these medicines.
- We ran a clinical search for patients taking azathioprine which is a disease modifying antirheumatic drugs (DMARD). We identified 64 patients on this medication, 14 had not received monitoring from their GP. We looked at a sample of 5 patient records in detail, 4 were receiving monitoring through secondary care. One patient required follow up monitoring.
- Vaccines were appropriately stored and monitored. Practice nurses and healthcare assistants were given dedicated time for monitoring stock control and expiry dates.
- The practice had processes in place to manage controlled drugs, this included managing stock levels, safely storing medication and disposal of controlled drugs.

| Dispensary services (where the practice provided a dispensary service) | Y/N/Partial |
|---|---|
| There was a GP responsible for providing effective leadership for the dispensary. | Y |
| 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. | Y |

| | |
|---|---|
| Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency. | Y |
| Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patents. There was a risk assessment or surgery policy for exceptions such as acute prescriptions. | Y |
| Medicines stock was appropriately managed and disposed of, and staff kept appropriate records. | Y |
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective. | Y |
| 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. | Y |
| If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability. | Y |
| Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence. | Y |
| Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc. | Y |
| There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians. | Y |
| Explanation of any answers and other comments on dispensary services:<br>• The practice had a named GP who provided leadership for the dispensary. The dispensing staff were supported by a pharmacist and could instantly contact other GPs if support was needed.<br>• Medicines stock was managed effectively. Stock was ordered when necessary so there was not an oversupply of medication<br>• All members of the dispensing team had access to report incidents and recorded near misses.<br>• There were risk assessments in place to ensure the dispensary delivery service operated appropriately. | |

**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: | 107 |
| Number of events that required action: | 83 |
| Explanation of any answers and additional evidence: | |

- Staff questionnaires received by CQC highlighted that members of staff understood the process for raising and reporting incidents.
- The practice had regular meetings where significant events where discussed and learning was shared. A GP partner was the lead and had oversight of the significant events process.

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

| Event | Specific action taken |
|---|---|
| Items being taken out of emergency drugs bag. | The practice noticed that when carrying out checks on the emergency drugs bags that stock had been taken out and not replaced. A system was now in place so that the bags are sealed with a tag and dated to indicate when they have been opened. |
| Incorrect patient details inputted on clinical system. | The organisation noticed a trend through incidents that the incorrect patients were being booked for appointments and that tasks were created in error with the wrong patient details. Due to the size of the patient list it was more common for multiple patients with the same name. As a result of this the practice implemented a new way of working so when searching for a patient the date of birth would be used first then the name to ensure the correct patient details were matched. |

| Safety alerts | Y/N/Partial |
|---|---|
| There was a system for recording and acting on safety alerts. | Y |
| Staff understood how to deal with alerts. | Y |

Explanation of any answers and additional evidence:

- When a safety alert was received it was the lead clinical pharmacist's responsibility to ensure it was actioned. The alert was put on GP TeamNet which is a platform which allows GP practices to manage compliance, HR and other related activities. The alert would then be sent to the relevant people who would have to sign to say that it had been read and actioned. The pharmacist could then easily track when alerts had been completed.
- We looked in detail at 5 patient records following an MHRA alert for patients aged 65 or older on a high dose of citalopram or escitalopram. All 5 patient records showed that there had been a discussion with the patient about the risks associated with taking this medicine.

# Effective Rating: Good

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

**Effective needs assessment, care and treatment**

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

| | Y/N/Partial |
|---|---|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.[1] | Y |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.[2] | Y |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Y |
| Patients' treatment was regularly reviewed and updated.[3] | Y |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |
| The practice prioritised care for their most clinically vulnerable patients. | Y |

## 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.<br>• Health checks, including frailty assessments, were offered to patients over 75 years of age.<br>• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.<br>• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.<br>• 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.<br>• All patients with a learning disability were offered an annual health check.<br>• 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**

- 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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice 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.
- Patients with asthma were offered an asthma management plan.
- Our clinical searches showed patients with asthma who needed rescue steroids were assessed appropriately, there was evidence of regular asthma reviews.
- We identified that 306 diabetic patients had retinopathy and their last HbA1c reading was above 74. Only 1 patient had not had a recall in the last 12 months.
- We also looked at patients who potentially had a missed diagnosis of diabetes. Our clinical searches identified 207 patients. We looked at 5 patient records, 4 were coded correctly as pre-diabetes. One patient required further monitoring and was being actively contacted by the practice to attend for monitoring.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|---|---|---|---|---|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 232 | 245 | 94.7% | Met 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received | 242 | 265 | 91.3% | Met 90% minimum |

| | | | | |
|---|---|---|---|---|
| Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | | | | |
| 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) | 242 | 265 | 91.3% | Met 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 242 | 265 | 91.3% | 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) | 302 | 323 | 93.5% | Met 90% minimum |

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

## Any additional evidence or comments

- The practice were proactively contacting patients to get them booked in for immunisations and educating patients on the importance of having them.
- The organisation identified this as an area of concern and have increased the workforce size from three members of staff to 12.
- More appointments for child immunisations are being offered through the enhanced access scheme which allows greater flexibility for attending these appointments. The organisation offered appointments for immunisations on weekends as well to try and improve uptake.

| Cancer Indicators | Practice | SICBL average | England average | England comparison |
|---|---|---|---|---|
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency) | 71.9% | 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) | 57.0% | 62.2% | 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) | 69.3% | 70.8% | 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) | 62.4% | 55.6% | 55.4% | No statistical variation |

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

| Any additional evidence or comments |
|---|
| • The practice had a plan in place to improve the rates of patients having cervical cancer screening. This included employing 2 new practice nurses so that more appointments were offered.<br>• Bank nurses were utilised to free up cervical screening appointments with other nurses.<br>• Nurses tried to engage with patients to go for screening, this included a practice nurse making appointments with patients so they could come into the practice to talk about the procedure and go through their concerns and worries with the patient to reassure them. |

**Monitoring care and treatment**

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

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

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

- The practice ran an audit to monitor the amount of apixaban prescribed as a result of a significant event were a patient was prescribed too much medication. Apixaban is a direct-acting oral anticoagulant (DOAC) used for the treatment of deep vein thrombosis (DVT and pulmonary embolism (PE). The pharmacy team identified two patients that been prescribed apixaban 5mg twice a day. As part of the significant event process, it was decided to identify all patients prescribed apixaban 5mg twice a day for longer than 6 months. Searches on the clinical system carried out in September 2021 showed 74 patients were prescribed apixaban 5mg twice a day, 48 patients were identified as needing the dose to either be reduced or stopped. The search was repeated in November 2021, 19 patients were identified and 15 of these patients needed their dose reduced. The search was run for a third time in September 2022, only 9 patients were identified, 5 of which needed a dose reduction. This audit has reduced the number of patients needing to be prescribed this medication.
- The practice carried out an audit looking at the rates of child immunisations. This audit provided recommendations for improving uptake of child immunisations. This included ensuring that immunisations were started on time. There should be regular reviews of overdue children. When the child came in for their first appointment the nursing team would book them in for their next immunisations. Every child who is not brought to an appointment is reviewed and staff are to keep trying to see the patient when multiple appointments are not attended. This was a single audit, so we were not able to see the improvements following the recommendations.

**Effective staffing**

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

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

Explanation of any answers and additional evidence:

- The practice had a comprehensive structure in place for learning and development. The organisation identified job roles that were difficult to recruit for. We saw an embedded culture of “grow our own” was in place. This was seen throughout the organisation. They trained GP registrars and were then able to offer successful GP’s, salaried GP roles before giving them the chance to join the partnership.

- The practice identified that practice nurses were particularly difficult to employ so they had started developing healthcare staff to become nurse associates, hoping that later they would qualify as nurses. Recruiting qualified dispensers was also an area of concern. The practice had recently employed 2 dispensary assistants who would be trained to qualified dispenser roles.
- The practice had a structured induction system for all members of staff. Staff worked through this induction with support from managers and colleagues until they were deemed competent.

**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 |
| Explanation of any answers and additional evidence:<br>• Care coordinators were able to directly refer patients through to social prescribers and health coach. | |

**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 |
| • 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. | |

# Responsive Rating: Good

**Responding to and meeting people's needs**

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as good.

**Access to the service**

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

| | Y/N/Partial |
|---|---|
| Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice | Y |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online) | Y |
| Patients were able to make appointments in a way which met their needs | Y |
| There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded). | Y |
| Patients with most urgent needs had their care and treatment prioritised | Y |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages) | Y |

Explanation of any answers and additional evidence:

- The practice offered a range of appointment types, this included face to face, telephone and video consultations.
- The provider used an online platform called Klinik for patients to access services online. This was available for patients from 8am Monday through till 6pm Friday. Patients used Klinik to access appointments, sicknotes and triage system. Klinik was monitored by care coordinators to ensure patients accessed the most appropriate services.
- Social prescribers were able to give mobile data to patients, so they were able to access online services.
- The practice had also worked with the patient participation group (PPG) to set up workshops on how to use the NHS App.
- The practice also offered appointments through the enhanced access scheme. Enhanced access is the offer, to registered patients of a practice, of pre-bookable appointments outside of core contractual hours, either in the early morning, evening or at weekends.

# Well-led Rating: Good

**Leadership capacity and capability**

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

| | Y/N/Partial |
|---|---|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |

Explanation of any answers and additional evidence:

- The organisation had identified job roles that were difficult to recruit for. We saw an embedded culture of “grow our own” staff was in place. The practice trained GP registrars and were then able to offer successful GP’s, salaried GP roles before giving them the chance to join the partnership which formed the organisations arrangements for succession planning.
- The practice identified that practice nurses were particularly difficult to employ so they had started developing healthcare staff to become nurse associates, hoping that later they would qualify as nurses. Recruiting qualified dispensers was also an area of concern. The practice had recently employed 2 dispensary assistants who would be trained to qualified dispenser roles.
- Staff feedback received from questionnaires was positive about how visible and approachable leaders were.
- The practice had systems in place to allow staff to develop into new roles. An example shared through the inspection showed a member of staff who started as an apprentice, worked through different roles before being seconded to a management role and then were successfully employed permanently in the role.

**Vision and strategy**

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

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

Explanation of any answers and additional evidence:

- The practice used a Practice Training and Learning (PTL) session to engage with staff so that everybody was involved in developingt the vision and values of the organisation. Staff questionnaires received highlighted that staff felt engaged and that they had developed the vision and values in collaboration with the senior management team.

**Culture**

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

| | Y/N/Partial |
|---|---|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Y |
| Staff reported that they felt able to raise concerns without fear of retribution. | Y |
| There was a strong emphasis on the safety and well-being of staff. | Y |
| There were systems to ensure compliance with the requirements of the duty of candour. | Y |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | Y |
| The practice encouraged candour, openness and honesty. | Y |
| The practice had access to a Freedom to Speak Up Guardian. | Y |
| Staff had undertaken equality and diversity training. | Y |
| Explanation of any answers and additional evidence:<br>• Staff feedback received highlighted that staff felt comfortable to raise concerns. Staff were also able to identify who the practice's Freedom to Speak Up Guardian was.<br>• Staff members also had access to Occupational Health services when required.<br>• Staff told us they felt well supported by managers and would be happy to go to them if they required more support.<br>• We looked at the complaints process. When it was identified that things went wrong patients were informed and apologies were given. | |

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

| Source | Feedback |
|---|---|
| CQC completed electronic staff questionnaires | The overwhelming majority of responses to staff questionnaires we received were positive about working as a team. 18 out of 19 responses received advised that they felt supported by their managers. |

**Governance arrangements**

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

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

**Managing risks, issues and performance**

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

| | Y/N/Partial |
|---|---|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Y |
| There were processes to manage performance. | Y |
| There was a quality improvement programme in place. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| Explanation of any answers and additional evidence:<br>• The practice had a disaster recovery policy. This would be followed in the event of a major incident. This was a step by step guide on what to do and who to contact depending on the incident that had occurred.<br>• The practice had 7 sites which meant they had resilience should any incidents affect specific sites. | |

**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 |

## Governance and oversight of remote services

| | Y/N/Partial |
|---|---|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y |
| The provider was registered as a data controller with the Information Commissioner's Office. | Y |
| Patient records were held in line with guidance and requirements. | Y |
| Patients were informed and consent obtained if interactions were recorded. | Y |
| The practice ensured patients were informed how their records were stored and managed. | Y |
| Patients were made aware of the information sharing protocol before online services were delivered. | Y |

| | |
|---|---|
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Y |
| Online consultations took place in appropriate environments to ensure confidentiality. | Y |
| The practice advised patients on how to protect their online information. | Y |
| Staff are supported to work remotely where applicable. | Y |

**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 |
| Explanation of any answers and additional evidence:<br>• The practice had an active Patient Participation Group (PPG) that it engaged with regularly.<br>• Following feedback from staff the practice changed from using controlled drugs books to binders which has modernised their way of working and aligned with external pharmacies. | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| We received a mix response from the PPG with some positive comments but also some negative comments about the organisation. They told us:<br>• The Head of Patient Services does an excellent job facilitating meetings and feeding back issues.<br>• They praised the patience of the reception and administration team when working in such a busy environment.<br>• They wanted more face to face appointments to be made available and wanted to have more time in appointments to talk about everything rather than just the presenting symptoms.<br>• They appreciated that the dispensary was busy but wanted more staff to help with this.<br>• Although they felt engaged with the provider there was still some uncertainty about what the PPG's role was and at times "felt like it was a tick box exercise". |

**Continuous improvement and innovation**

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

| | Y/N/Partial |
|---|---|
| There was a strong focus on continuous learning and improvement. | Y |

| | |
|---|---|
| Learning was shared effectively and used to make improvements. | Y |

| Examples of continuous learning and improvement |
|---|
| The practice had been working to improve how long it takes to get through on the telephone. In October 2021 the average time spent queuing to speak to somebody on the phone was 39 minutes. In May 2022 the provider opened a new “hub” where the administration and telephony had been relocated to. The new telephone system enabled the management of call handlers and allowed the provider to monitor telephone statistics in real time. The practice had used this information to analyse when their busiest times were so that staffing could be mapped alongside this. Since the hub opened in May the average time spent queueing on the telephone had been less than 9 minutes. The vacation of the administration staff to the hub meant the extra space could be utilised for clinical activity. |

**Notes: CQC GP Insight**

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

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