

## Inspection Evidence Table

Woodcock Road Surgery

(1-551488982)

**Inspection Date: 11 October 2023**

Date of data download: 06/09/2023

**Overall rating: Good**

## Context

Information published by the Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the second lowest decile (2 of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 2.3% Asian, 93.8% White, 1.4% Black, 2% Mixed, and 0.4% Other.

The age distribution of the practice population shows a lower number of older people and a higher number of working age and young people according to the local and national averages.

The practice shared information relating to patients on their inclusion health register. (Inclusion Health is a locally enhanced service commissioned by the Integrated Care Board). The register included patients who were asylum seekers or refugees, homeless or living in a hostel, from gypsy or Romany communities, sex workers, people released from prison and patients with chronic forensic psychiatric needs. For some of these patients, longer appointments and interpreter services in languages of Arabic and Farsi were essential.

The practice had seen a consistent increase in the practice list size year on year, mainly due to new housing developments in their area.

Review of the GP Patient survey data for the past 3 years has seen the practice perform consistently above the national and local averages. The practice had processes in place to monitor patient demand and adjust their appointment systems.

**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 <sup>1</sup> |
| 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:<br>The practice had a clear electronic system to ensure all staff had received training they deemed mandatory. We saw some non-clinical staff were trained to level 1 for safeguarding children, but we noted all staff had booked training slots to increase to level 2 safeguarding children. They practice prioritised face to face training for staff wherever possible. |                |

| 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           |

| Safety systems and records   | Y/N/Partial    |
|--|----------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. | Y              |
| Date of last assessment: May 2021  | Y <sup>1</sup> |
| There was a fire procedure.  | Y              |
| Date of fire risk assessment: May 2021   | Y <sup>2</sup> |
| Actions from fire risk assessment were identified and completed.                       | Y              |

Explanation of any answers and additional evidence:  
 The practice evidenced they had a proactive approach to health and safety. They held a detailed risk register which was regularly monitored, and actions completed. This register included risk assessments such as staff well-being, management of legionella (a bacteria that can multiply water systems) and premises checks.

1. The last external health and safety assessment was May 2021. The staff we spoke with told us the management team regularly undertook checks including workstation assessments.
2. The last external fire risk assessment with a report was May 2021. However, an external assessment had been undertaken 3 October 2023, but the practice was still awaiting the report. Actions from the 2021 assessment had been carried out. These included ensuring checks on the emergency lights had been completed.

**Infection prevention and control**

**Appropriate standards of cleanliness and hygiene were met.**

|   | Y/N/Partial    |
|---|----------------|
| Staff had received effective training on infection prevention and control.  | Y              |
| Infection prevention and control audits were carried out.   | Y              |
| Date of last infection prevention and control audit: 22 August 2023   | Y <sup>1</sup> |
| 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:<br>1. The practice had carried out a detailed infection, prevention, and control (IPC) audit. They had systems to monitor that action had been completed. For example, improving the documentation to record that equipment had been cleaned after consultations. |                |

**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:   |             |

Feedback we received from staff was positive about the practice approach to staffing levels. The practice recognised they required some additional staff and were recruiting more staff, staff told us they covered for each other for planned or unexpected leave.

**Information to deliver safe care and treatment.**

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

|  | Y/N/Partial    |
|--|----------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.  | Y <sup>1</sup> |
| There was a system for processing information relating to new patients including the summarising of new patient notes.   | Y <sup>2</sup> |
| 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              |
| <p>Explanation of any answers and additional evidence:</p> <p>1. Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.</p> <p>2. The practice had a backlog of medical records that had not been fully summarised. They had completed the electronic transfer of medical records and had easy access to the paper records. Where the paper records had not been checked against the electronic version, the practice coded the records to reflect this. They had completed a risk assessment to ensure records were prioritised for summarising. The practice had recruited a new staff member to undertake this role, but they had not yet started their employment.</p> |                |

**Appropriate and safe use of medicines**

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

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

| Indicator   | Practice | SICBL average | England | England comparison       |
|---|----------|---------------|---------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small>  | 0.84     | 1.03          | 0.91    | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small> | 6.7%     | 9.8%          | 7.8%    | No statistical variation |

|  |        |        |        |                                      |
|--|--------|--------|--------|--------------------------------------|
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA) | 5.39   | 5.79   | 5.24   | No statistical variation             |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)  | 224.2‰ | 193.9‰ | 129.5‰ | No statistical variation             |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)   | 1.14   | 0.85   | 0.54   | Tending towards variation (negative) |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)   | 18.0‰  | 12.0‰  | 6.8‰   | Significant variation (negative)     |

#### Explanation of any answers

The practice was aware of their higher prescribing data for Star-PU on hypnotics. They served a deprived area linked with high mental health needs. They also delivered care to forensic psychiatric patients who are prescribed these medicines. These patients had regular psychiatrist reviews who had overseen the medicine(s) prescribed to these vulnerable patients.

The practice told us that of the 125 patients on antipsychotic combinations or combinations of antipsychotics with antidepressants, 70% were under regular follow-up and medicine reviews with the secondary care mental health teams. For the remaining 30%, the practice prescribed under a shared care agreement but took specialist guidance on the dose and quantities of hypnotics and other medicines relating to their mental health needs.

The practice worked closely with the PCN mental health practitioner and had a direct referral process for the Wellbeing Service, who were linked with social prescribers to support patients with often multifactorial mental health needs.

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 <sup>1</sup> |
| There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.   | Y <sup>2</sup> |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.                                | Y              |

|   |                |
|---|----------------|
| There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.   | Y <sup>3</sup> |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).   | Y              |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.   | Y              |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.  | N/A            |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.   | Y              |
| For remote or online prescribing there were effective protocols for verifying patient identity.   | Y              |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.   | Y              |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.  | Y              |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.   | Y              |
| <p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>1. The practice did not directly employ any non-medical prescribers; however, they had the support of a pharmacist from the primary care network. The practice showed they had a clear understanding and oversight of the work undertaken by the staff member.</p> <p>2. As part of our inspection, we reviewed some patient records to ensure medicines had been prescribed safely. We reviewed 5 records and found all records contained sufficient detail to be assured all medicines had been reviewed. Our clinical searches identified 70 patients out of 222 who were prescribed gabapentionoids (pain relief medicines) who had not received a review in the past 12 months. We reviewed 5 patient records and found 4 were overdue a review. The practice showed evidence that all 70 patients had been identified and that a planned programme of appointments had been booked. We saw that this work had been recognised and the system to managed was established and in place prior to our inspection. We saw the appointments booked were with the clinical pharmacist and were longer appointment length to ensure sufficient time was available for the discussion between the pharmacist and the patient. Records were coded to ensure regular recalls for reviews by GPs. Where patients had not responded and booked an appointment or had not attended, the practice showed they were actively reviewing the quantity of medicines prescribed.</p> <p>3. Our clinical searches showed that patients prescribed high risk medicines were monitored within the appropriate timeframes. Where patients had not been compliant with attending for blood tests the practice had reduced the quantity of medicines to ensure patients attended their appointments. The practice had a system in place to extract information from correspondence when patients had received their monitoring in hospital.</p> |                |

**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:  | 12          |
| Number of events that required action:  | 12          |

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

| Event  | Specific action taken   |
|--|---|
| Patient received written information from the hospital about changes to the medicines. The patient's first language was not English and they had continued on the wrong dose as they did not understand the information. | The practice identified that the patient had not changed the amount of medicine they were taking. They reviewed and found no patient harm had occurred. Practice implemented system to ensure that patients who first language was not English or who could not read English, were given verbal instruction about any changes in medicines.   |
| Aggressive and inappropriate behaviour by member of the public.  | The incident was dealt with appropriately at the time, staff reported they had been fully supported by colleagues and the police were involved. The practice team wrote the event form and as a team discussed the event. They looked for any opportunities that staff may have had or might have in the future to manage the situation differently.  |
| Medical emergency in the practice.   | Following a medical emergency in the practice, the team recognised that they had used a large amount of the contents of the oxygen cylinder. They reflected that should a second emergency happen or a delay in the ambulance arriving they may run out. The practice bought a second cylinder for their emergency equipment to ensure they would have sufficient oxygen at hand if required. |

| 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:<br>The practice had a system to receive and action the safety alerts they received via electronic systems. There was a lead GP for reviewing them (with cover for any absence to ensure there was not a delay in managing |             |

any alerts). As part of our clinical searches, we reviewed an alert that was issued to ensure patients on a SGLT2 inhibitor (a medicine used to lower blood sugar) had received information about the additional risks of diabetic ketoacidosis (DKA) and Fournier’s gangrene. Our search identified 94 patients on the medicine. We reviewed 5 patients records and found 4 patients had received the information. The practice shared the leaflet that was given to all patients regarding these risks but noted that it was not always coded in the patient records. The practice took immediate action, re issued all patients with the leaflet and coded the records.

## 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 were 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. | Y           |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>  | Y           |
| We saw no evidence of discrimination when staff made care and treatment decisions.   | Y           |
| Patients’ treatment was regularly reviewed and updated. <sup>3</sup>   | Y           |
| There were appropriate referral pathways to make sure that patients’ needs were addressed.   | Y           |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated.                               | Y           |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic.                                   | Y           |
| The practice prioritised care for their most clinically vulnerable patients.   | Y           |

### Effective care for the practice population

#### Findings



- Those patients 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. The practice had completed 402 health checks in the past 12 months. 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. The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. They currently had 68 patients on their register. The practice team was working with a Health Improvement Nurse employed by the Integrated Care Board (ICB) and in June and September 2023 the nurse had delivered training to the practice staff in learning disability awareness and completing health checks. The nurse was supporting the practice to review all patients on their register to ensure they have been appropriately identified and supported. The practice had in the past 12 months completed 36 annual health reviews, some of these in patients' own homes. They told us, with the additional training the staff had received, they had the resources and skills to ensure all patients with a learning disability would be reviewed by March 2024. The practice also worked with the community teams to ensure any patients to support where patients needed encouragement to attend the practice.
- 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 including to clinics in the practice. The practice worked with a mental health practitioner and offered 40-minute appointments for patients. These appointments were for face-to-face consultations. The practice told us they were flexible with appointment times to meet the needs of any patient in a mental health crisis situation.
- There were clinical leads for different issues including family planning, children's feeding options and support and easy access for anyone experiencing domestic abuse. The practice support young people with easy access for sexual health advice. They provided appointments for long-acting contraceptive devices in the practice.
- The practice offered patients appointments with a first contact physiotherapist. This practitioner saw any patient aged over 14 years old with musculoskeletal problems.

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs had not always followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. Our clinical search identified 55 patients had been prescribed 2 or more courses of rescue steroids. We reviewed 5 patient records and found 3 had not

received a follow up within one week. The practice took immediate action and sent reminders to all prescribing staff to ensure they booked a follow up call or appointment with any patient prescribed a course of rescue steroids.

- Patients with COPD were offered rescue packs.
- 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. Our clinical search identified that 13 patients may have a potential missed diagnosis of diabetes. We reviewed 5 of these records and found all patients had been managed appropriately and their records were coded accurately.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- The clinical searches identified 236 patients diagnosed with hypothyroidism and 9 of these had not received the appropriate monitoring. We reviewed 5 patient's records and found 4 were overdue their blood tests. One patient had undertaken monitoring tests in hospital and the practice had access to the results. We saw the practice had acted and contacted the patients but had not in all cases considered reducing the quantity of medicine prescribed. The practice told us their policy was to reduce the quantity of medicine prescribed to encourage patients to attend their monitoring appointments. The practice took immediate action and reminded all prescribing staff to follow the practice policy when prescribing this medicine.

| 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 influenzae type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 95        | 101         | 94.1%    | Met 90% minimum                 |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)  | 78        | 86          | 90.7%    | Met 90% minimum                 |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)   | 77        | 86          | 89.5%    | Below 90% minimum               |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)   | 77        | 86          | 89.5%    | Below 90% minimum               |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)  | 81        | 92          | 88.0%    | Below 90% minimum               |

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

### Any additional evidence or comments

The practice was aware of the lower performance for childhood immunisations. They had a proactive approach to contacting the parents and guardians of children who did not attend their immunisations appointments. For those who did not make an appointment the practice contacted them, used information in the parent/guardian's first language to discuss any concerns they may have. Where they were not able to encourage attendance, the practice liaised with the health visiting team. The practice told us they were flexible with appointment times, to enable those parents/guardians who worked, to bring the children at times convenient to them. The practice recognised they served a population of patients who may have taken their children abroad for their vaccinations, they asked parents/guardians for the details so they could add the information to the patient records. In addition, they recognised that the culture of some of the practice population chose not to have their children immunised.

| Cancer Indicators   | Practice | SICBL average | England | England comparison       |
|---|----------|---------------|---------|--------------------------|
| Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)  | 62.3%    | N/A           | 62.3%   | N/A                      |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)   | 67.2%    | N/A           | 70.3%   | N/A                      |
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (3/31/2023 to 3/31/2023) (UKHSA) | 69.4%    | N/A           | 80.0%   | Below 70% uptake         |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)  | 50.0%    | 54.4%         | 54.9%   | No statistical variation |

### Any additional evidence or comments

The practice was aware of their lower performance for cervical screening. The practice was proactive in contacting patients to discuss any concerns and to follow up any patients who did not attend their appointments. The practice offered flexible appointment times to enable those patients who worked to attend at times that were convenient to them. The practice recognised they served a population of patients who preferred not to attend for screening. The practice used information leaflets and interpreters to encourage those patients whose first language was not English to attend the screening programme.

### Monitoring care and treatment

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

|   | Y/N/Partial |
|---|-------------|
| Clinicians took part in national and local quality improvement initiatives.   | Y           |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.  | Y           |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.  | Y           |
| <p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice provided evidence to show they had a comprehensive programme of quality improvement and used audits as one method to manage quality, safety, and well-being. They had undertaken quality improvements including clinical and non-clinical projects. The audits including those relating to proactive health such as non-diabetic hyperglycaemia, quality of cervical screening sample takers, quality of referrals, looking at those rejected and identifying learning outcomes.</p> |             |

#### Any additional evidence or comments

An audit was undertaken looking at the UK Medical Eligibility criteria for Contraceptive use (UKMEC). The UKMEC helped clinicians decide on what contraception could be safely considered for patients given any other medical conditions they may have. The second audit cycle showed improvements in the practice ensuring the score was recorded and that clinical staff used the template available within the clinical system. At the meeting held to discuss the results, the clinicians discussed issues that could affect decision making including managing high blood pressure for patients taking oral contraceptives.

A prescribing audit (cycle 1) was undertaken in respect of patients prescribed Pregabalin. The practice audit cycle showed the number of patients that had not had a medicines review in the last 6 months. An action plan was developed, and protocol agreed with the clinical pharmacist to review all patients offering face to face appointments.

#### 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 |
|---|---|

**Coordinating care and treatment**

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

|   | Y/N/Partial |
|---|-------------|
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Y           |
| Patients received consistent, coordinated, person-centred care when they moved between services.                    | Y           |

**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           |

**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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.   | Y <sup>1</sup> |
| <p>Explanation of any answers and additional evidence.</p> <p>1.As part of our inspection, we reviewed 4 patients records with a recorded entry of a DNACPR form. The practice demonstrated a person-centred approach to completing these and recording decisions. In 2 cases, we found a recent form had been completed by the hospital. The practice had reviewed this with the patient/relatives and ensured it was still relevant. Where the practice had completed the form, a signed copy was in the patient medical records, where the form had been completed elsewhere clear documentation was in the record of the decision, that the form was held in the patient's home. Where discussions had been started but the patient declined to continue or make a decision, this was also documented. The information was clearly available for out of hours providers should they require it.</p> |                |

## 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           |

| Patient feedback                         |   |
|--|---|
| Source                                   | Feedback  |
| CQC Share my care                        | We received feedback from 10 patients and of these, 7 gave wholly positive feedback about the care and treatment delivered by the practice. Two of the other 3 contained mixed feedback with 1 reporting poor attitude of a staff member.   |
| NHS.uk website (formerly NHS Choices)    | One comment had been posted on the website rating the practice 5 stars. The comment was positive about the care and compassion delivered by the practice.   |
| Healthwatch                              | In the past 12 months 22 comments have been posted on the website. Of these 12 comments rated the practice 5 stars, 6 rated with 4 stars, 1 rated 3 stars, 2 rated with 2 stars and 1 rated with 1 star. The practice had responded to all comments. The negative comments did not relate to the care attitude of staff but related to treatment decision made by clinicians. |
| Practice own patient satisfaction survey | In September 2023, the practice undertook their own survey of patient satisfaction, over 300 forms were completed or partially completed. Of those who completed the question 98% said they found reception staff very or fairly helpful and 2% said they found them not helpful.   |

## National GP Patient Survey results

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

| Indicator   | Practice | SICBL average | England | England comparison       |
|---|----------|---------------|---------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)                   | 87.7%    | 87.2%         | 85.0%   | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023) | 84.6%    | 86.4%         | 83.8%   | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)                              | 96.2%    | 94.2%         | 93.0%   | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)   | 77.7%    | 74.7%         | 71.3%   | No statistical variation |

### Any additional evidence or comments

We noted the data from the GP patient survey showed the practice had consistently (over the past 3 years) performed as well as or better than the national average in all questions. One area where the practice still performed in line with the national average, but which had reduced over the past 2 years was the percentage of patients who reported the healthcare professional was good or very good at listening to them. The practice had reviewed all the data from the GP patient survey to discuss at their clinical and practice meetings.

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

### Any additional evidence

The practice had completed their own patient survey during September 2023. Over 300 forms had been completed or partially completed. Areas where patients had put comments were reviewed and the practice had developed a plan to address the issues where appropriate. As a practice team, they planned (late October 2023) to discuss the results in detail.

The practice also encouraged patients to send their feedback via the Friends and Family system. In July 2023, 124 patients left their feedback and 90% rated the practice as good and above. In August 2023, 137 patients left their feedback and 90% rated the practice good and above. In September 2023, 132 patients left their feedback and 93% rated the practice as good and above.

## Involvement in decisions about care and treatment

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

|  | Y/N/Partial |
|--|-------------|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.  | Y           |
| Staff helped patients and their carers find further information and access community and advocacy services.  | Y           |
| Explanation of any answers and additional evidence:<br>Easy read and pictorial materials were available and in other languages. The practice was proactive to provide information in the patients first language if possible. Where patients may not be able to read, the practice ensured verbal information was shared using interpreter services as needed. |             |

| Source                           | Feedback  |
|----------------------------------|---|
| Feedback received from patients. | We received feedback from 10 patients and of these 7 gave wholly positive feedback about the care and treatment delivered by the practice including that they understood and were engaged in decision making. Two of the other 3 contained mixed feedback with 1 reporting poor attitude of a staff member. |

## National GP Patient Survey results

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

| Indicator  | Practice | SICBL average | England | England comparison       |
|--|----------|---------------|---------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023) | 95.1%    | 92.0%         | 90.3%   | No statistical variation |

### Any additional evidence or comments

We reviewed the GP patient survey data for the past 3 years and found the practice had consistently performed in line or above the national average.

|   | 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           |

| Carers | Narrative |
|--------|-----------|
|--------|-----------|



|   |  |
|---|--|
| Percentage and number of carers identified.                 | The practice had identified 245 patients (2.8% of practice population) as carers.  |
| How the practice supported carers (including young carers). | The practice had a staff member who was a carers champion. The practice identified new patients who were carers when they registered at the practice but also during consultations. The practice added a flag to the carers medical records to ensure flexibility is given when booking appointments. The practice had a process to annually review all carers records to ensure their register was up to date and all carers were invited to appropriate appointments such as flu vaccinations. |
| How the practice supported recently bereaved patients.      | The practice clinical staff contacted any bereaved patients and arranged any necessary appointments or home visits to ensure they were supported during this difficult time.   |

### 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           |

## Responsive

## Rating: Good

Information published by the Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the second lowest decile (2 of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 2.3% Asian, 93.8% White, 1.4% Black, 2% Mixed, and 0.4% Other.

The age distribution of the practice population shows a lower number of older people and a higher number of working age and young people according to the local and national averages.

The practice shared information relating to patients on their inclusion health register, (Inclusion Health was a locally enhanced service commissioned by the Integrated Care Board). The register included patients who were asylum seekers or refugees, homeless or living in a hostel, from gypsy or Romany communities, sex workers people released from prison and for some patients with chronic forensic psychiatric patients. They were also a Veteran Friendly practice. For some of these patients, longer appointments and interpreter services in languages of Arabic and Farsi were essential.

The practice had seen a consistent increase in the practice list size year on year mainly due to new housing developments in their area.

Review of the GP Patient survey data has seen the practice perform consistently above the national and local averages. The practice had processes in place to monitor patient demand and adjust their appointment systems.

The practice had undertaken their own patient satisfaction survey in September 2023. The results of this survey were positive. Areas where patients had negative feedback had been reviewed and to be discussed with the practice team in October 2023. The practice also encouraged patients to send their feedback via the Friends and Family system.

### 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 <sup>1</sup> |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided.   | Y              |
| The facilities and premises were appropriate for the services being delivered.  | Y              |
| The practice made reasonable adjustments when patients found it hard to access services.  | Y              |
| There were arrangements in place for people who need translation services.  | Y              |
| The practice complied with the Accessible Information Standard.   | Y              |
| Explanation of any answers and additional evidence:<br>1 The practice shared information relating to patients on their inclusion health register. (Inclusion Health was a locally enhanced service commissioned by the Integrated Care Board). The register included patients who were asylum seekers or refugees, homeless or living in a hostel, from gypsy or Romany communities, sex workers and people released from prison. For some of these patients, longer appointments and interpreter services in languages of Arabic and Farsi were essential. |                |

| Practice Opening Times  |              |
|---|--------------|
| Day   | Time         |
| Opening times:  |              |
| Monday  | 8am – 6.30pm |
| Tuesday   | 8am – 6.30pm |
| Wednesday   | 8am – 6.30pm |
| Thursday  | 8am – 6.30pm |
| Friday  | 8am – 6.30pm |
| Appointments were available at various times throughout the day. Extended access was provided the practice GP partners from 6.00pm to 7pm weekday evenings and locally by the Primary Care Network (PCN), where |              |

late evening and alternative weekend appointments were available. Out of hours services were provided between 6pm – 6.30pm by patients calling the East of England Ambulance Service and after 6.30pm patients were supported via the national 111 service.

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. Through working with the Primary Care Network, older patients who do not regularly attend the practice were contacted to ensure they did not have any unmet health needs or needed support.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional appointments were available until 7pm on Monday to Thursday for school age children so that they did not need to miss school. One of the GPs was a children's feeding champion.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 7pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a Primary Care Network (PCN).
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability. People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. They currently had 68 patients on their register. The practice team was working with a Health Improvement Nurse employed by the Integrated Care Board and in June and September 2023 the nurse had delivered training to the practice staff in learning disability awareness and completing health checks. The nurse was supporting the practice with a review of all patients on their register to ensure they have been appropriately identified and supported. The practice had in the past 12 months completed 36 annual health reviews, some of these in patients own homes. They told us, with the additional training the staff had received, they had the resources and skills to ensure all patients with a learning disability would be reviewed by March 2024. The practice also worked with the community teams to ensure any patients to support where patients needed encouragement to attend the practice.
- There were clinical leads for different issues including family planning, children's feeding options and support and easy access for any patients experiencing domestic abuse. The practice supported young people with easy access for sexual health advice. They provided appointments for long-acting contraceptive devices in the practice.
- The practice worked with a mental health practitioner and offered 40-minute appointments for patients. These appointments were for face-to-face consultations. The practice told us they were flexible with appointment times to meet the needs of any patient in a mental health crisis situation.
- The practice offered patients appointments with a first contact physiotherapist. This practitioner saw any patient aged over 14 years old with musculoskeletal problems.

### Access to the service

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

Y/N/Partial

|   |                |
|---|----------------|
| Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.   | Y              |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).   | Y <sup>1</sup> |
| Patients were able to make appointments in a way which met their needs.   | Y <sup>2</sup> |
| There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).  | Y              |
| Patients with most urgent needs had their care and treatment prioritised.   | Y              |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages).   | Y              |
| <p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. The practice offered a range of appointment types. These included face to face, telephone consultations and responded to some queries as appropriate by text message.</li> <li>2. Patients were able to make appointments by online system, in person or via the telephone. The practice recognised that more patients still preferred to contact the practice via the telephone. The practice offered extended hours in the practice between 6pm and 7pm four evenings a week.</li> </ol> |                |

### National GP Patient Survey results

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

| Indicator   | Practice | SICBL average | England | England comparison       |
|---|----------|---------------|---------|--------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023) | 71.5%    | N/A           | 49.6%   | Variation (positive)     |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)                             | 74.0%    | 59.1%         | 54.4%   | No statistical variation |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)                    | 65.1%    | 56.1%         | 52.8%   | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)                             | 82.5%    | 76.1%         | 72.0%   | No statistical variation |

### Any additional evidence or comments

We reviewed the GP patient survey data for the past 3 years and found the practice consistently performed above the national average. We noted that the indicator relating to patients who were satisfied or fairly satisfied

with their GP appointments times had reduced along with the national satisfaction rates. The data reflected the practice performance was still above the national average.

The practice had completed their own patient survey, they included questions they considered relevant to their patients. For example, of the 300 questions completed or partially completed 92% said they were satisfied with the type of appointment(s) they were offered. 88% of patients who completed the form stated they found it very easy or fairly easy to get through on the telephone. In addition, the practice asked questions such as why the patient did not take an appointment, was there a particular GP you refer to see or speak with and thinking of their last appointment were their needs met. The practice planned to further? discuss the findings at their next whole team meeting in October 2023.

The practice also encouraged patients to send their feedback via the Friends and Family system.

- In July 2023, 124 patients left their feedback and 90% rated the practice as good and above.
- In August 2023, 137 patients left their feedback and 90% rated the practice good and above.
- In September 2023, 132 patients left their feedback and 93% rated the practice as good and above.

| Source                                | Feedback  |
|---------------------------------------|---|
| CQC Share my care                     | We received feedback from 10 patients and of these 7 gave wholly positive feedback about the access to the practice. Two of the other 3 contained mixed feedback with 2 reporting difficulty in getting an appointment.   |
| NHS.uk website (formerly NHS Choices) | One comment had been posted on the website rating the practice 5 stars. The comment was positive about access to the practice.  |
| Healthwatch                           | In the past 12 months 22 comments have been posted on the website. Of these 12 comments rated the practice 5 stars, 6 rated with 4 stars, 1 rated 3 stars, 2 rated with 2 stars and 1 rated with 1 star. The practice had responded to all comments. Some of the negative comments related to difficulty in accessing the practice. |

### 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.                                    | 8 |
| Number of complaints we examined.  | 2 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 2 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman.   | 0 |

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

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|-----------|-----------------------|
|-----------|-----------------------|

|  |  |
|--|--|
| Delay in referral.   | The patient contacted the practice as they had not been given an appointment by the hospital. The practice immediately investigated the complaint. They discovered the referral had been done but an error had been made when sending to the hospital. The referral email had not been delivered and the practice had not picked up that it had been undelivered. The practice ensured the referral was sent, apologised to the patient, and undertook a learning event with staff to ensure any undelivered emails were investigated. |
| Practice picked up a negative report on the Healthwatch website.                     | The practice responded asking for the patient to contact them so that they could discuss the complaint. The patient did not respond, and the practice was unable to resolve the complaint.   |
| General feedback from comments left by patients using the Family and Friends system. | The practice had a notice board in the waiting room giving patient information and actions they had taken following any feedback they had received. This included information about booking appointments, increases to the number of telephone lines and private room facilities for patients who wished to feed their children.   |

## 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           |

### 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 <sup>1</sup> |
| Staff knew and understood the vision, values and strategy and their role in achieving them.   | Y <sup>2</sup> |
| Progress against delivery of the strategy was monitored.  | Y <sup>3</sup> |
| Explanation of any answers and additional evidence:<br>1,2&3 The practice mission statement was "Your health, welfare and safety matters to us". All staff we spoke with or had a completed questionnaire from told us they had worked together as a cohesive team to write their mission statement. Staff told us they were fully involved in delivering the strategy and part of the continuous monitoring to ensure they continued to deliver high quality services to their patients. |                |

## 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 <sup>1</sup> |
| 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>1. The practice demonstrated a proactive approach to staff wellbeing. This included social events, regular meetings (daily huddles), access to occupational health services and health and safety to ensure a safe and appropriate working environment. Staff told us the GP partners and practice manager were approachable and supportive. |                |

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

| Source   | Feedback   |
|--|--|
| From staff we spoke with and from staff questionnaires.    | .All feedback we received was positive about the team working within the practice. Staff described the culture as open, supportive, and friendly. Staff told us they were listened to and were respected for their skills and input to the care of patients.                         |
| The practice had undertaken a staff survey in August 2023. | Results from the staff survey were shared with staff and actions that have been identified from the feedback was being discussed at the October protected learning day. The staff were positive in their response to all questions including their well-being and work life balance. |

### **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           |

### **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 <sup>1</sup> |
| The practice had an active Patient Participation Group.  | Y              |
| Staff views were reflected in the planning and delivery of services.   | Y              |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.   | Y              |
| <p>Explanation of any answers and additional evidence:<br/> The practice had a notice board in the waiting room giving patient information and actions they had taken following any feedback they had received. This included information about booking appointments, increases to the number of telephone lines and private room facilities for patients who wished to feed their children.</p> |                |

Feedback from Patient Participation Group.

| Feedback  |
|---|
| <p>We spoke with a member of the PPG who was positive about the practice and the relationship with the PPG members. Meetings had been held and the practice staff had attended. They told us the practice listened to feedback for the group and showed respect for the opinion. The practice also shared information with the group, discussing such topics as the practice telephone system and trainee GPs. The PPG member told us the practice had a range of patients on the group including a younger patient. This enabled a wider patients view to be shared with the practice.</p> |

## Continuous improvement and innovation

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

|   | Y/N/Partial |
|---|-------------|
| There was a strong focus on continuous learning and improvement.  | Y           |
| Learning was shared effectively and used to make improvements.  | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice demonstrated and staff confirmed the GP partners were proactive in offering and supporting staff development. Several members of staff had originally joined the practice on apprenticeship schemes and had through their training development progressed to different roles within the practice. For example, from being in the reception team, staff had progressed to take other responsibilities within the administration of the practice or moved into a clinical role such as phlebotomist. Since the last inspection the practice had become a training practice for doctors training to be GPs and for medical students.</p> <p>The GPs valued face to face training for staff where possible. For example, in July 2023 a GP undertook a face-to-face training session for all staff in managing suspected sepsis and other medical emergencies. This training included written slides and information for reflective learning.</p> <p>Through this inspection, the practice demonstrated they were aware and knowledgeable about continuous learning from good practice, changes to national and local guidelines and services.</p> |             |

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

| Variation Bands                  | Z-score threshold |
|----------------------------------|-------------------|
| Significant variation (positive) | ≤-3               |
| Variation (positive)             | >-3 and ≤-2       |

|                                      |                      |
|--------------------------------------|----------------------|
| Tending towards variation (positive) | $>-2$ and $\leq-1.5$ |
| No statistical variation             | $<1.5$ and $>-1.5$   |
| Tending towards variation (negative) | $\geq 1.5$ and $<2$  |
| Variation (negative)                 | $\geq 2$ and $<3$    |
| Significant variation (negative)     | $\geq 3$             |

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

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

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

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

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

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

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