Care Quality Commission

Inspection Evidence Table

Dr Joann Amin (1-502672016)

Inspection Date: 27 June 2023

Overall rating: Good

We carried out an inspection at Dr Joann Amin, also known as The Willows Medical Practice, on 22 July 2022. The practice was rated requires improvement overall; the key questions of safe, effective and well led were rated as required improvement. We found breaches of Regulation 17 (Good governance) and 19 (Fit and proper persons employed).

At this inspection, on 27 June 2023, we found improvements had been made to the service, but some areas required further improvement. We have rated the practice good overall; the keys questions of safe, caring, responsive and well-led are rated as good. Effective is rated as requires improvement. We found a breach of Regulations 12 (Safe care and treatment).

Safe Rating: Good

At the last inspection in July 2022, we rated the practice as requires improvement for providing safe services because:

- Recruitment checks were not always carried out in accordance with regulations.
- The practice did not hold appropriate emergency medicines, have risk assessments in place to determine the range or medicines held, or an effective system in place to monitor stock levels and expiry dates.

At this inspection we have rated the practice as good for providing safe services as the breach of regulation had been complied with.

Safety systems and processes

The practice had clear systems and practices keep people safe and safeguarded from abuse.

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

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence: • Following the inspection, the provider was able to supply us with evidence confirming that locum staff had received appropriate checks on their suitability.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment:	June 2023
There was a fire procedure.	Yes
Date of fire risk assessment:	January 2023
Actions from fire risk assessment were identified and completed.	Yes

Explanation of any answers and additional evidence: • At the last inspection the lead GP had not completed fire warden training. The lead GP had now completed the fire warden training which meant there were 2 trained fire wardens at the practice.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit:	May 2023
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: • The practice manager completed a monthly audit of the cleanliness and safety of the practice premises. This was evidenced on the electronic management system which set an alert for the next audit. Evidence of changes and improvements made was also stored on the electronic system. • Hand hygiene audits were carried out 6 monthly. • The infection prevention and control (IPC) policy did not state how often a clinical IPC audit would be completed by a trained individual and the policy should be reviewed to include this.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes
Explanation of any answers and additional evidence: • We reviewed 6 staff members training and found they had all completed sepsis awareness training.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: • Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.	

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) (01/04/2022 to 31/03/2023) (NHSBSA)	1.07	0.95	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). (01/04/2022 to 31/03/2023) (NHSBSA)	7.3%	8.7%	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 (01/10/2022 to 31/03/2023) (NHSBSA)	4.46	4.95	5.23	No statistical variation

Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	230.5‰	195.2‰	129.8‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	1.56	0.48	0.55	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	8.7‰	7.3‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence, including from clinical searches: • The practice had put appropriate risk assessments in place and all emergency medicines we saw were in date and in stock.	

- As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice.
- The records we examined provided evidence that most patients prescribed high risk medicines had been monitored appropriately. Patients were receiving appropriate monitoring.
- Not all patients had an alert warning that the patient was on an immunosuppressive drug.
- A non-prescriber clinical staff member had coded that they had completed a medication review. This was flagged to the lead GP.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	20
Explanation of any answers and additional evidence: • Since July 2022 the practice had recorded 20 incidents. • Significant events were discussed during practice meetings. Learning was shared with all staff.	

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

Event	Specific action taken
Patient reported side effects to their medication that were not expected. When the GP investigated this, they found that the patient had been dispensed the incorrect medication contrary to the prescription.	Alerted the pharmacy that dispensed the medication. Reiterated to patients that if they started to feel unwell or if there were any changes to their symptoms they should present back to the GP or call 111 for advice.
When entering the surgery in the morning staff found an open window in a clinical room. No sign of forced entry.	This was raised with NHS property services to ensure the building was secure each night.

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

Effective Rating: Requires Improvement

At the last inspection in July 2022, we rated the practice as requires improvement for providing effective services because:

- The practice was unable to demonstrate that some clinical staff had the skills, knowledge and experience to carry out their roles.

At this inspection we have rated the practice as requires improvement for providing effective services. We identified the following areas of concern:

- Dementia care plans were not effective.
- Management of long-term conditions was not always effectively monitored.
- The practice did not consistently record repeated consent to care and treatment in line with legislation and guidance.

Effective needs assessment, care and treatment

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

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

Effective care for the practice population

Findings
As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. The results from the searches were visible to the practice. • We reviewed 5 dementia care plans. We saw 4 of the 5 did not contain enough evidence that the reviewer had discussed the patient's current medical conditions, performed physical examination and considered the patient's wishes. Our CQC GP specialist advisor concluded the documented consultation did not constitute an effective dementia review. We also found that: • 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. • All patients with a learning disability were offered an annual health check. • End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. • The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. • The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. • Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings
As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. The results from the searches were visible to the practice. • We found 12 patients who had potentially undiagnosed diabetes during our clinical searches. We reviewed 5 patient records in detail. We found that all 5 patients were not always reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. We told the practice about these patients on the day of inspection. • Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care. We found 11 patients out of 131 patients were identified as having had two or more courses of oral steroids for asthma exacerbations in the last 12 months. We reviewed 5 patient records in more detail. Evidence was not consistently seen of asthma management plans being discussed with patients; three patients had not had an asthma management review in the past 12 months. We saw 3 patients had not been followed up within a week of being issued with a course of steroids as would be good practice in accordance with NICE guidance and 4 patients should be issued with a steroid emergency card as per a national patient safety alert in 2020. • Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance; we saw there were 94 patients with hypothyroidism, the searches identified that 6 had not received the appropriate monitoring or review. We reviewed a random sample of 5 records and found that 1 had not had their long-term condition managed in line with recommended

guidance. We saw evidence of the practice attempting to arrange blood tests with 4 patients before our inspection.

- We found 4 patients diagnosed with atrial fibrillation (a condition that causes an irregular heart rate) had not been prescribed an anticoagulant to reduce the risk of stroke. We saw 1 declined and 1 did not engage with the practice. We saw no record of why the other 2 patients were not prescribed anticoagulants. We raised this with the practice during the inspection.
- Patients with long-term conditions were offered an 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.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	34	37	91.9%	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)	43	51	84.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	43	51	84.3%	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)	44	51	86.3%	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)	30	35	85.7%	Below 90% minimum

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

Any additional evidence or comments
• The location had a relatively small patient list, which potentially impacted on the percentage of uptake. We saw that the practice had a strategy to address the figures, which were lower than the national target. They had recruited and trained a receptionist to take a lead on liaising with families about childhood immunisations to try to improve uptake.

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)	60.1%	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)	62%	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). (Snapshot: 31/12/2022) (UKHSA)	63.4%	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)	41.7%	49.8%	54.9%	No statistical variation

Any additional evidence or comments
• The practice provided their own unverified data for cervical screening. For ages 25-49 they recorded an 82% screening rate and for ages 50-64 an 80% screening rate as of 31 May 2023. They told us they were a high achieving practice for cervical screening and were advising other practices how to improve their cervical screening data. • The practice told us they could book patients in to extended access for cervical screening appointments. • Patients who were identified as eligible for cervical screening were reviewed weekly. Patients received 2 letters from public health, the practice would then send a text message with a link for patients to book their own appointment, the message also included information about the screening. We have told the provider they should continue to develop their strategy to improve uptake of cervical screening.

Monitoring care and treatment

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

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

The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
• The practice sent us two examples of quality improvement work they had conducted and explained that this was an ongoing process. • The practice manager had developed an audit based on the CQC 5 key questions. At the time of inspection, the safe audit was being used. The practice planned to complete the 5 audits every 5 months when they were all developed.	

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles except for all locum doctors used.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: • At the last inspection the practice could not evidence that some clinical staff had completed necessary training to carry out their roles. At this inspection we reviewed training records for 6 staff members and found evidence of completion for all 6 staff.	

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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

Helping patients to live healthier lives

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

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

Consent to care and treatment

The practice did not always obtain consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial
Explanation of any answers and additional evidence: • During the review of patient records we saw that consent was not recorded for a patient who had a steroid joint injection. We raised this with the lead GP. They stated it was not documented due to the patient having had previous injections, so they were aware of the risks. We have told the provider they should be assured that consent is consistently recorded on the patient record. • The practice told us four patients had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions. The lead GP told us they did not have copies of these as they were put in place by other organisations involved in the patients care. • The lead GP told us they never reviewed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions.	

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.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: • We reviewed 6 staff training files; they had all completed equality and diversity training. • We observed reception staff speaking respectfully to patients in the waiting area and on the phone.	

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 (01/01/2022 to 30/04/2022)	78.4%	85.7%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	78.1%	84.5%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	80.6%	92.8%	93.1%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	78.5%	72.4%	72.4%	No statistical variation

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

Any additional evidence
• The practice reviewed the friends and family information and created an action plan to address any concerns, this was discussed in the practice meeting. • The practice intended to start asking patients through text message about access to the practice. • The practice had a patient information area in the waiting room, this had comment slips and a box to submit them.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment / patients were not 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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: • Easy read patient information leaflets were available.	

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 (01/01/2022 to 30/04/2022)	81.4%	90.0%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	The practice had a register of 39 (1%) carers.
How the practice supported carers (including young carers).	The practice would refer carers to the council provided Carers Service who would provide information and advice. The practice website had a page for carers with links to information and support.
How the practice supported recently bereaved patients.	The practice had an ‘at times of bereavement’ link on the website but this is for registering the death and arranging the funeral, it did not mention what support is available.

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.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: • If patients wanted to speak in private to reception staff, they were able to speak to the side of the desk away from the waiting area or they would find a room to speak privately.	

Responsive Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: • The practice was based on the ground floor with level access throughout.	

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
GP appointments available:	
Monday	9am – 11.30pm and 3.30pm – 5.30pm
Tuesday	9am – 11.30pm and 3.30pm – 5.30pm
Wednesday	9am – 11.30pm and 3.30pm – 5.30pm
Thursday	9am – 11.30pm and 3.30pm – 5.30pm
Friday	9am – 11.30pm and 3.30pm – 5.30pm
Nurse appointments available:	
Every other Wednesday	8.30am – 1pm and 1.30pm – 5pm

Friday	8.30am – 1pm and 1.30pm – 5pm

Further information about how the practice is responding to the needs of their population
• The practice was able to book patients into the extended access hub provided by the primary care network. Each practice was allocated a number of appointments based on patient list size. These appointments could be used for urgent on the day appointments, children, bloods and cervical screening. The appointments were available 5pm-8pm Monday to Friday and on Saturdays 9am – 5pm. • Patients had a named GP. • 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. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. • 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.

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.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes

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 (01/01/2022 to 30/04/2022)	87.3%	N/A	52.7%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall	59.8%	55.7%	56.2%	No statistical variation

experience of making an appointment (01/01/2022 to 30/04/2022)				
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	62.4%	55.1%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	65.5%	69.9%	71.9%	No statistical variation

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.	3
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3

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

- Information about how to complain was available on the practice website. Patients had to navigate to practice policies to find information about how to make a complaint.
- The practice had a complaint leaflet available in the waiting area. This leaflet detailed contact details to make a complaint in writing, it was not clear that patients could complain verbally.
- Staff told us they could assist patients to make a compliant.

Example(s) of learning from complaints.

Complaint	Specific action taken
July 2022. Complaint that a prescription had not been authorised within 48 hours.	This was investigated and it was found that an incorrect form had been completed. However, discussion in a practice meeting found that not all staff were aware of the current process for ordering prescriptions so this was used for learning. The request for a prescription was actioned as soon as the practice became aware of the issue, and a letter of apology and an explanation was sent to the patient.

Well-led Rating: Good

At the last inspection in July 2022, we rated the practice as requires improvement for providing well led services because:

- The practice had not identified the actions necessary to address challenges to quality and sustainable care.
- The practice did not always have clear and effective processes for managing risks, issues and performance.
- Some governance and assurance systems were not effective.
- There were limited systems and processes for learning, continuous improvement and innovation.

We saw that these issues had been addressed at this inspection.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	N/k
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: • The lead GP had plans to employ a salaried GP with a view to partnership. The lead GP had plans in place should they not be able to work to ensure patients could still access care.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: • Staff told us they were involved and that their passions and ideas were included. • The practice had reviewed their vision and strategy since our last inspection.	

- The practice had a mission statement: “To provide professional, accessible, high quality, comprehensive healthcare services that inspires confidence in our patients and our community”. This was also on the website.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: • At the last inspection there was no evidence that all staff had completed equality and diversity training. At this inspection we reviewed 6 staff files, and all had completed the training. • At the last inspection some staff had told us they did not always feel able to raise concerns, some stated that their concerns or suggestions for improvement were not always valued. At this inspection all staff feedback responses were stated they felt able to raise concerns without fear of retribution.	

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

Source	Feedback
Staff Feedback Form	The practice can be busy and sometimes stressful, but staff are mostly friendly and supportive to each other.
Staff Feedback Form	The practice has a supportive friendly atmosphere. The practice offers a triage service which is quick and very efficient, this means a fast turnaround on patient's queries and prescription requests.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

Managing risks, issues and performance

The practice had clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:

- At the last inspection the practice did not provide evidence of an ongoing programme of quality improvement for clinical practice. At this inspection the practice provided a quality audit they had begun to develop based on the fundamental standards and CQC key lines of enquiry; safe, effective, caring, responsive and well led. At the time of inspection, the practice had made progress on the audit based on safe. The practice explained they intended to do the audit every 5 months.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making. However, information was not always accurate.

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

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: • Since our last inspection the practice set up a patient participation group (PPG) and had had 2 meetings. • The practice had a comments box in reception for patients to leave feedback. • The practice could demonstrate they were actively involved with their primary care network (PCN) to build a shared view of challenges and ways to help the practice meet the needs of their patients. For example, the practice employed a physiotherapist with PCN funds to see patients at the medical practice.	

Feedback from Patient Participation Group.

Feedback
A member of the PPG said, 'the practice is fantastic at keeping the patients up to date, it is very quick to get an appointment and always I am referred to the right clinic quickly.' Another member of the PPG said, 'it would be nice for everyone to have a name badge, so the patients know who they were speaking to.' The practice then put this in place.

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

Explanation of any answers and additional evidence:

- At the last inspection we reviewed 3 sets of practice meeting minutes. It was not clear whether all clinical staff received a copy of the meeting minutes when they could not attend. At this inspection staff feedback indicated that they were given copies of the minutes of the meeting, and these were available in the staff area.
- Learning from complaints and incidents was discussed in the practice meeting minutes we reviewed.
- The practice created action plans to address patient feedback and discussed these in practice meetings.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease.
- **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.