

Care Quality Commission

Inspection Evidence Table

Dr's Bacon, Wrigley & Chomicka (1-568374545)

Inspection date: 20 July 2022

Date of data download: 12 July 2022

Overall rating: Good

Safe

Rating: Requires improvement

We have rated the practice as requires improvement because;

- We found the practice system and process in place for risk assessments relating to security, safe recruitment and health and safety had not wholly mitigated risks to patients and staff.
- We found the practice system and process to manage and regularly review safety alerts had not ensured all patients were kept safe.
- From the records we reviewed we found detailed information relating to structured medicines reviews however we found some medicines had not been linked to specific conditions.
- The practice did not have a system to document competency assessments or reviews to ensure staff were competent to undertake their roles and to identify any learning needs.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial ¹

Safeguarding	Y/N/Partial
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 ²
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. On the day of inspection we found no evidence of a Disclosure and Barring Service (DBS) check in place for a staff member who had access to patient information and was employed by the practice. Although, evidence of a confidentiality agreement was provided. The practice took immediate action and started the process of a DBS risk assessment and submission of a DBS check. All other staff had received appropriate DBS checks. 2. We saw evidence of meeting minutes that the practice had discussed safeguarding at clinical meetings, health visitors, midwives, social worker and school nurse had attended these meetings. The practice told us they were able to contact the health visitor and school nurse if they had concerns about children or needed advice. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 21/02/2022	Partial ¹
There was a fire procedure.	Yes
Date of fire risk assessment: 12/11/2021 Actions from fire risk assessment were identified and completed.	Partial ²
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. The practice had a legionella risk assessment and they had decided due to the water tanks maintaining suitable temperatures, and that they had no showers or air conditioning units that the risk of legionella was low. However, the practice could not evidence the temperature of the water tanks, nor the temperature of water from the sinks to be assured that the risk was low. The practice took immediate action and contacted an external agency to conduct a site visit. 2. The recent fire risk assessment undertaken by the practice had identified there was no emergency lighting at the practice. The practice assessed the risk and mitigated the risk due to the skylights that were in place. However, we cannot be assured these risks were fully mitigated as the risk assessment did not detail changes in light such as wintertime. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 20/05/2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes ¹
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: 1. We found evidence of actions taken from the infection prevention and control (IPC) audit including flooring in all the clinical rooms had been replaced from carpet to hard floors.	

Risks to patients

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

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

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.	Partial ¹
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes

There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: 1. Whilst we found most records were stored securely, due to the constraints of insufficient space we found some records were stored within open office areas. The practice told us they had discussed this with the integrated care board (ICB) and had not fully completed a formal written risk assessment to mitigate risks such as all staff who may work in the area had received an appropriate DBS check.	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.82	0.87	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	13.0%	10.7%	8.8%	Tending towards variation (negative)
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 (01/10/2021 to 31/03/2022) (NHSBSA)	5.26	5.21	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	127.7‰	120.9‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.78	0.65	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	8.0‰	5.8‰	6.8‰	No statistical variation

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

Any additional evidence or comments
The practice was aware of some increase in in the prescribing of 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 which had occurred during the COVID-19 pandemic. We noted through their audit programme the practice had monitored this and over the past 12 month period the prescribing had improved. The practice was confident that the prescribing would continue to improve.

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.	Partial ¹
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial ²
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	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
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.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

1. Staff told us they had easy access to GPs for clinical support should they need it. In addition, they had joint appointments with patients to discuss cases and findings. We saw cases were discussed and learning shared in staff meetings where minutes were recorded. Staff had regular appraisals and were part of clinical audits, such as use of antibiotics. They told us they did not have formal documentation of discussions of case studies between individual clinical staff to monitor quality and staff competencies. The practice provided evidence of a template that they would use in the future to record their cases studies.
2. As part of our inspection and with the consent of the practice, we used a suite of clinical searches and reviewed some patient medical records. We found medical records were clear to show all medicines and risks had been considered by the clinician. However, we found some medicines reviews which had not been linked to the condition for which they had been prescribed.

As part of our inspection, we conducted a search of patients with Chronic Kidney Disease (CKD) stages four or five who have not received appropriate monitoring in the last nine months. We found 204 patients of which three patients were identified as not being monitored. We reviewed these records and found evidence to show these patients were being managed and appropriately monitored by secondary care.

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:	16
Number of events that required action:	6
Explanation of any answers and additional evidence: We reviewed the practice records for recording events and outcomes. We found the practice had a system to ensure events and learning were shared with all team members. Staff told us there were various ways they reported any concerns but that they did not have a standard system. We discussed this with the practice who took immediate action to review and standardise a reporting form for all staff to use.	

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

Event	Specific action taken
Delay in non-urgent referral	The referral process had been updated to task referrals to ensure they were completed, also to ask patients to contact practice within a week if they haven't received correspondence.
Delay in triage via online system	The email inbox folder was not checked for online queries, system changed to ensure queries were sent directly to the main inbox and are now checked twice daily.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial ¹
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: 1. As part of the inspection, we used clinical searches to review the practice system to ensure action on safety alerts. Generally, we found the system was well managed. However, we found a historical alert relating to a medicine and the increased risk of skin cancer whilst taking this medication had not been acted on appropriately. We found 36 patients taking this medicine. We reviewed five records and found the practice had not discussed the risk with the patients. We discussed this with the practice who took immediate action to review these patients. Immediately following our inspection, the practice informed us that they reviewed their system for managing safety alerts to included monitoring of all historical alerts.	

A second search was conducted relating to a recent alert of medicines and the impact on women of childbearing age. We identified 14 patients all of which had been informed by the practice.

Following our searches, we found the systems and processes had been improved and the practice could evidence that safety alerts had been actioned appropriately, however, this system needed further embedding.

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

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

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. The practice had identified 1023 patients and had currently carried out 224 health checks.
- All 74 patients with a learning disability were offered an annual health check, the practice had completed 56.

- 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.
- Patients that were palliative, end of life, patients with long term conditions, vulnerable adults and patients with mental health problems were discussed with members of the Multi-disciplinary team (MDT) at monthly meetings. These patients have a named doctor to ensure that patients and their families were provided with effective care and support in their own homes.

Management of people with long term conditions

Findings

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.
- Patients that are palliative, end of life, patients with long term conditions, vulnerable adults and patients with mental health problems are discussed with members of the Multi-disciplinary team (MDT) at monthly meetings. These patients have a named doctor to ensure that patients and their families are provided with effective care and support in their own homes.
- The practice had doctors and members of the nursing team that had areas of specialism for example diabetes and chronic obstructive pulmonary disease (COPD) and lead on these conditions.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
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The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	64	64	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	61	61	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	61	61	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	59	61	96.7%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	83	92	90.2%	Met 90% minimum

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

Any additional evidence or comments

The practice continued to meet performance target's during the COVID-19 pandemic. The practice had met the target on five indicators and 100% on three indicators. This was due to the monitoring of performance and management of clinics needed to meet targets. The patient list size had grown over the last 12 months and as a result, more appointments were made available to meet the needs of patient demand.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to	72.8%	N/A	80% Target	Below 80% target

64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	49.6%	55.7%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	67.7%	68.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	45.0%	61.2%	55.4%	No statistical variation

Any additional evidence or comments

The practice was aware of the figures in respect of cervical screening from December 2021 and had discussed this in clinical meetings, the practice provided appointments before 9am and after 5pm, they had changed their appointment system to double their capacity for clinics, they contacted and monitored patients who had failed to attend. Until new data is published, we are unable to assess whether the actions taken have improved uptake.

Monitoring care and treatment

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

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

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

The practice had a programme of targeted quality improvement such as clinical audits.

An audit conducted 2019 in respect of patients taking Disease-modifying anti-rheumatic drugs (DMARDs), showed 51 patients were taking DMARDs and four patients had not received the appropriate monitoring, the practice also noted where the hospital was monitoring patients, they hadn't updated their system with recent results.

Due to COVID-19 pandemic the practice conducted the second cycle in 2022, 58 patients were taking DMARDs and the audit showed one patient had not received the appropriate monitoring. The practice made changes such as scheduling tasks to ensure correspondence of blood tests from hospitals was actioned on their system and to contact patients to book their blood tests.

The practice had provided teaching sessions to share learning of the findings with other staff.

Any additional evidence or comments

- Due to difficulties of face to face training during the pandemic the practice improved their induction booklets for new starters, this included a guide for their computer system.
- The practice introduced a telephone messaging system which allowed patients to give feedback on their care and be reminded of appointments.
- Introduction of new recall and long term condition (LTC) templates helped create a holistic approach to patient care and overall effectiveness of LTC reviews.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes ¹
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:

1. Staff told us they had easy access to GPs for clinical support should they need it. In addition, they had joint appointments with patients to discuss cases and findings. We saw cases were discussed and learning shared in staff meetings where minutes were recorded. Staff had regular appraisals and were part of clinical audits, such as use of antibiotics. They told us they did not have formal documentation of discussions of case studies between individual clinical staff to monitor quality and staff competencies. The practice provided evidence of a template that they would use in the future to record their cases studies.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes ¹
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <ol style="list-style-type: none"> The practice had Multidisciplinary team meetings monthly which included practice leads, social care prescriber, midwife, health visitor, school nurse and GP social worker. They also had palliative care meetings four weekly with the district nurse and palliative care nurse. 	

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 ¹
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: <ol style="list-style-type: none"> The practice told us and we had evidence of a case which had a team approach to support a patient, the case had been discussed in clinical meetings. The patient was followed up and, this led to the patient being able to self-referring to gain further support. There was health prevention information in forms of posters and leaflets for patients in the waiting room. 	

Consent to care and treatment

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

	Y/N/Partial
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Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The practice leaders demonstrated clear leadership and oversight. We identified some issues in respect of providing safe services. The leaders were responsive in implementing changes to mitigate those concerns. As these changes were newly implemented the practice told us they would monitor them to ensure they were effective and sustained.	

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.	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

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 ¹
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:	
<ol style="list-style-type: none"> The practice had an up to date health and safety risk assessment with actions completed, as part of their staff wellbeing the practice ensured staff were supported and allowed breaks after pressurised activities such as patient complaints. Staff told us about team building activities outside of work and birthday buffets for staff. 	

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

Source	Feedback
Staff questionnaires and feedback	<ul style="list-style-type: none"> Staff told us there was a good working culture and all staff were supportive. Staff spoke highly of leaders, they told us they were approachable and able to raise concerns. Staff told us it was a very patient orientated practice.

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.	Partial ¹
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> The practice had a system of regular meetings where structures and systems were reviewed, nurses told us they had protected time to complete continuing professional development (CPD), infection prevention and control (IPC) audits and clinical audits. However, we found work was required to improve systems and processes, for example, fire safety, legionella risk assessment and DBS checks. We spoke with leaders and staff about some of these concerns, they told us they had implemented some changes on the day of and immediately after our remote and onsite inspection. For example, contact was made with an external company regarding a site visit for legionella risk assessment and a DBS risk assessment was in process for a staff member. These changes need to be embedded and monitored to ensure they are sustained to keep patients and staff safe from harm. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial ¹
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	
1. The practice used risk assessments to understand and mitigate any risks for example a fire risk assessment, management of legionella and medical record storage. However, these risk assessments had not been wholly effective, as some risks had not been fully identified or mitigated.	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes ¹
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence:	

1. Staff told us they felt safe at work during the pandemic and when changes were made, they were informed.

Appropriate and accurate information

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

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

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes ¹
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
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Explanation of any answers and additional evidence:

1. The practice recently reinstated the Patient Participation Group (PPG) which had 14 active members and the practice engaged with the group every 3 months. The practice manager and GP partners attend the meetings to discuss practice information with the group. Changes had been considered due to feedback from the PPG, for example, the practice telephone system had been updated to alert patients of their position in the queue and the practice had reached out for volunteers to support upcoming flu clinics.

Feedback from Patient Participation Group.

Feedback
Members of the PPG told us they were happy with the practices engagement and that they felt respected, listened to and part of the practices future during the meetings that were held.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
The practice continued to develop their staff through learning opportunities, staff told us of additional courses they had been on and qualifications gained with the support from the practice.	
The practice took opportunities to learn and improve the services offered, sharing information through learning events and meetings.	
The practice was a training practice for GP registrars.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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