

Care Quality Commission

Inspection Evidence Table

The Three Spires Medical Practice (1-581427309)

Inspection date: 6, 7 & 14 September 2022

Date of data download: 06 September 2022

Overall rating: Good

Safe

Rating: Good

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

Safety systems and processes

- The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. Staff had the information they needed to deliver safe care and treatment and the practice learned and made improvements when things went wrong.
- There were adequate systems to assess, monitor and manage risks to patient safety and appropriate standards of cleanliness and hygiene were met.
- The practice had systems for the appropriate and safe use of medicines. Ongoing monitoring was being maintained with actions taken to follow up late reviews.

| 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 |

| Safeguarding | Y/N/Partial |
|---|-------------|
| <ul style="list-style-type: none"> The practice had a safeguarding lead GP who oversaw all concerns. Safeguarding concerns were discussed weekly or sooner if needed. Safeguarding risk registers were maintained, and staff were made aware of children in care. Meetings were recorded to ensure an audit trail of discussion and any actions needed were taken. Child protection meetings were held by the GPs at the practice. The appropriate staff were invited to attend, and minutes were used to record all discussions and actions. | |

| 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 |
| <ul style="list-style-type: none"> We reviewed the personnel folders for five members of staff. We saw that for those staff who required it, a Disclosure and Barring (DBS) check had been received and references had been obtained for all staff before commencing employment. Staff were interviewed prior to the appointment and a record of the interview was kept. This meant the practice was able to demonstrate the candidate had met the requirements for the role. Clinicians required to register with a professional body had evidence to demonstrate they were up to date with their registrations. | |

| Safety systems and records | Y/N/Partial |
|---|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: | Yes |
| There was a fire procedure. | Yes |
| Date of fire risk assessment: 16/06/2022 Actions from fire risk assessment were identified and completed. | Yes |
| <ul style="list-style-type: none"> Drills for emergency evacuation have been practiced and members of staff were aware of their responsibilities in the event of a fire or other emergency. Designated staff were fire wardens. All consultation and treatment rooms had been equipped with panic buttons for the use of staff members in the instance of an emergency or dangerous situation with a patient. The alarm would notify the reception desk and enable assistance to be called. | |

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: | Yes |
| 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 |
| <ul style="list-style-type: none"> • The environment was purpose-built. There were risk assessments for infection prevention and control (IPC) for the building and the practice had an IPC policy. • Cleaning contracts were in place for cleaning both clinical and non-clinical areas. Audits of the standard of environmental hygiene were ongoing and reviewed by the business manager. • We observed staff took measures to reduce the risk of COVID-19 infection. We saw staff wore personal protective equipment including masks and gloves when required. For patients and staff, alcohol gel was located at the entrance and throughout the building. There was signage reminding people to use the hand gel. The practice had taken action to follow national guidance to reduce the number of patients attending the practice during the COVID-19 pandemic, the current changes were ongoing at the time of inspection. • Clinical waste storage was available in clinical rooms. Sharps boxes were dated and signed when first in use and again when ready for disposal. This enabled an audit trail of their use. Storage of clinical waste was held securely until collected. • All equipment had stickers identifying that servicing and checks were in date. | |

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 |
| <ul style="list-style-type: none"> • Staffing levels were planned to ensure there was enough coverage for periods of leave such as annual leave or to cover sickness. Temporary staff were provided with induction training and support to ensure they were able to work safely. • Reception staff had access to a GP if they had concerns about the wellbeing of patients waiting in reception or on a telephone call. | |

- There was signage and flow charts to inform staff of actions to take in an emergency. Staff were provided with training in basic life support and how to deal with medical emergencies.

Information to deliver safe care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹ | 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 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 |
| <ul style="list-style-type: none"> • All new patients registered with the practice completed a registration form and had medicine and medical history review carried out by a nurse or doctor, depending on their health conditions. For example, those patients with a long-term conditions or those taking complex medicines. • There was a process used which required staff to update the electronic record system with the patient's historical, paper-based records. Staff received training in the process. Not all records were up to date as new staff were training for this role and this had impacted on the records reviewed. Temporary staff had been employed to catch up with the shortfall. The practice managed between 100 and 250 records coming into the practice each month Staff were being recruited to permanently manage this role meet the service needs and to manage the current backlog of 190 records. • The practice had a system to manage test results and ensured prompt clinical oversight of the tests. If the requesting clinician was not available to review the results, another GP would ensure the results were seen and actioned. | |

Appropriate and safe use of medicines

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

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

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA) | 0.91 | 0.83 | 0.82 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA) | 8.7% | 9.1% | 8.5% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA) | 5.98 | 5.39 | 5.31 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 141.2‰ | 151.8‰ | 128.0‰ | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA) | 1.29 | 0.65 | 0.59 | Tending towards variation (negative) |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA) | 8.3‰ | 6.9‰ | 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 |

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Yes |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹ | 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. ² | Partial |
| 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. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | 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 |
| <ul style="list-style-type: none"> • Three Spires Medical Practice employed a lead pharmacist and three non-medical prescribers. All three non-medical prescribers had a prescribing qualification and were also mentored by clinicians within the practice. • Medicine reviews were in the process of being completed by the lead pharmacist and GP. A trained pharmacy technician completed post-hospital discharge medicine reviews using a formulated template to ensure the required areas were covered. The reviews were supervised by the Lead Pharmacist and were used as a training opportunity. • The pharmacy staff attend prescribing meetings to review any areas requiring action and share learning. The lead nurse also attends prescribing meetings to ensure actions were shared. • Patient medicine reviews were scheduled annually or in between times as needed. There were systems in place to provide a safety net so that all patients needing a medicine review were not missed. A procedure was in place for patients who would not engage with the review which included a series of communications. This was managed to encourage the patient to participate in the review for their safety. | |

- The practice pharmacist team visited local designated care homes for medication reviews and medicine optimisation, they also reviewed patients' medicines with long-term conditions. They checked patients were on the right medications for their conditions, and that their symptoms and risk factors were well controlled.
- The Pharmacy team explained their involvement in a wide range of medicine and pharmaceutically related workflows. Those included, medication reviews, structured medication reviews, care home medication reviews, medicines reconciliation, discharge medicines reviews, outpatient letters medication and safety and medication alerts. Those workflows were used to inform medical staff and improve patient safety.
- Prescriptions were mostly provided electronically. When paper prescriptions were used, the prescriptions were stored securely and logged to ensure their security.
- We looked at clinical records for patients who were prescribed a disease-modifying anti-rheumatic drugs (DMARDs). We saw that the practice had a good recall system for some medicines. However, we looked at five patient's records who were being prescribed Leflunomide. This medicine is used to treat rheumatoid arthritis. We saw that of the five records reviewed, not all five had all aspects of the monitoring required. We saw that each of the records (with one exception) had some level of monitoring, but the system used for full monitoring had not been consistently maintained. The lead clinician for the service explained that the monitoring had taken place but there were some issues with the computer system picking up codes used to record monitoring, but this was reviewed by the practice and any shortfalls identified and actions taken.
- We reviewed the records of 15 patients prescribed Lithium. This is a medicine used as a mood stabilising medicine. We saw that three of the 15 patients whose records we checked had not had appropriate monitoring in line with the national guidance. The lead clinician followed up those patients during the inspection and appropriate monitoring had been arranged.
- The average daily quantity of Nitrofurantoin 50 mg tablets and capsules used for uncomplicated urinary tract infections was above the national average. This was being reviewed by the practice as part of all antibiotic monitoring with a view to address any causes for the elevated rate.
- The average daily quantity of hypnotics, medicines used to induce, extend or improve the quality of sleep, being prescribed exceeded the England average. This was being monitored by the practice by an ongoing audit. Any variations or exceptions were tasked for review by the individual doctor concerned. Further training for pain management was booked to support the development of a practice-wide strategy to reduce the use of those medicines.
- The use of Gabapentin medicines (an anticonvulsant medicine used to treat epilepsy as well as anxiety and some pain types of pain relief) was required to be monitored to ensure the appropriate dosage was being used. At the time of inspection, we identified 230 patients who did not have a record of review in the last 12 months, we looked at five individual records and saw that only one of the five had had a recent medicines review. The clinical lead confirmed that the recording of these reviews was an electronic coding issue and the practice business manager confirmed that these reviews were underway. The practice clinical staff explained that some delays were created by the COVID-19 pandemic and this shortfall was being addressed by training a doctor to undertake those reviews. This work was ongoing and under control.
- All medications were stored securely. Stock levels were monitored for the usage of medicines. We saw that three oxygen cylinders were not secured to prevent them from falling over and causing harm. The business manager was advised and stated they would ensure they were stored securely.

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 | Yes |
| Number of events that required action: | 15 |
| <ul style="list-style-type: none"> The provider had reporting systems to capture incidents and errors that required investigation and any learning outcomes were shared with staff through meetings and ongoing discussion. This demonstrated that if something did go wrong, appropriate action would be taken, and learning would be shared with staff to prevent reoccurrence. We saw that significant events were reported, managed and monitored and learning was shared with staff. In response to each significant event, an investigation and analysis had been completed by the business manager to identify the cause and establish a solution to the problem. Significant events were also reviewed at a weekly clinical meeting and practice meetings. Minutes of the meetings were shared to ensure learning from significant events was available to staff. | |

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

| Event | Specific action taken |
|--|--|
| <ul style="list-style-type: none"> A medicines fridge door was found open by morning staff. This could impact on the medicines stored inside. | <ul style="list-style-type: none"> None of the medicines were used. A system was implemented to ensure that the fridge door was checked each evening and staff signed to say they had checked. This was undertaken to prevent reoccurrence. |
| <ul style="list-style-type: none"> A patient had a missed injection which was not noted for over a year. | <ul style="list-style-type: none"> A system was implemented to provide a safety net to ensure any repeat injections were noted if missed. |

| Safety alerts | Y/N/Partial |
|--|-------------|
| There was a system for recording and acting on safety alerts. ¹ | Yes |

| | |
|--|-----|
| Staff understood how to deal with alerts. | Yes |
| <ul style="list-style-type: none"> • The practice had systems to ensure that safety alerts were shared with the appropriate staff members for action. Alerts and information were disseminated via clinical staff meetings, practice meetings, emails and by discussions. • There had been guidance produced by the Medicines and Healthcare Regulatory Agency (MHRA) regarding the combined prescribing of Omeprazole (a medicine to treat indigestion and heartburn) and Clopidogrel (a medicine to prevent platelets, a type of blood cell, from sticking together and forming a dangerous blood clot). This was due to the potential risk that Omeprazole can prevent or alter the absorption of Clopidogrel, therefore, reducing its effectiveness. During this inspection, we undertook searches of the practice's clinical patients' records system and we found that 81 patients were on this medicine combination. We saw that action had been taken and patients identified as at risk, had been contacted to and arrangements made by practice for review. • As a result of safety alerts, monitoring of risks was ongoing. The MHRA had identified that prescribing Pregabalin, a medicine used for treating neuropathic pain, general anxiety disorder and some seizures may have risks associated with its use during pregnancy. The alert identified that use during pregnancy should be avoided and the risks should be discussed with the patient. We looked at three patients' records, as part of our remote electronic searches, who were taking this medicine. None of the records showed the risks had been discussed with the patients. The practice told us that a doctor was currently being trained to review the gabapentin medicines (an anticonvulsant medicine used to treat epilepsy as well as anxiety and some pain types of pain relief) and this would include those patients on Pregabalin. | |

Effective

Rating: Good

- Patients' needs were assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.
- The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. Staff worked together and with other organisations to deliver effective care and treatment. The practice obtained consent to care and treatment in line with legislation and guidance

Effective needs assessment, care and treatment

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

| | Y/N/Partial |
|---|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | 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 | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. ³ | 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 |
| <ul style="list-style-type: none"> • The practice was a training practice and education afternoons were used to provide learning. the National Institute for Health and Care Excellence (NICE) compliance guidelines and any updates or changes in practice were discussed when needed. This meant staff were kept up to date with changes in good practice. • The practice audited the service outcomes to ensure they were confident of the service provided. • All new patients were assessed and reviewed to ensure clear oversight was maintained. Patients with ongoing conditions were monitored and reviewed including a review of their medicines. Patients presenting with new symptoms were referred when needed and followed up at the practice. | |

Effective care for the practice population

Findings

- Health checks were offered to patients if required. There was an appropriate and timely follow-up on the outcome of health assessments where abnormalities or risk factors had been identified.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder, including dementia. When required patients were referred to appropriate services. There was a mental health practitioner working within the practice.
- The practice website provided information, advice and signposting for a range of health promotion including stopping smoking, information for new parents, healthy weight and diabetes.
- All patients with a learning disability were offered an annual health check and support for vulnerable patients was maintained.
- The practice followed up on patients discharged from hospital. This ensured patient's care plans and prescriptions were updated to reflect any extra or changed needs.
- 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 social prescriber who visited the practice weekly.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. Staff who were responsible for reviews of patients with long-term conditions had received specific training for that role.
- Long-term condition monitoring had been suspended during the COVID-19 pandemic which had created a backlog of reviews. That backlog was being addressed by developments in how reviews were managed. The practice offered annual "birthday month" recalls for patients with long-term conditions. The practice had nine long-term conditions clinics spread out over the week, offering appointments on weekdays. Since the COVID-19 pandemic, the practice had been offering a range of different appointment types to ease access for patients. This included seeing patients for multiple conditions in one clinic appointment.
- The practice nursing team had specialised areas of training and expertise in diabetes, asthma, chronic obstructive pulmonary disease and ischemic heart disease. Previously the practice had reviewed the conditions separately, but had moved towards a more holistic review, where they aimed for the patients to have all their conditions reviewed within the same consultation. Patients with greater needs could be seen by the nurse several times a year. This would be when medications were titrated to reduce patients risk factors or improve control of their condition, or it could be patients who were particularly vulnerable needing more support.

- The practice worked closely with the local Diabetic Specialist Nurse who, once a month, ran a joint clinic in the surgery. The practice nurse leading on diabetes used an assessment algorithm to monitor patients at risk of unstable diabetes.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring. A new patient accessible blood pressure monitor had been purchased at the time of the inspection and was to be implemented to allow greater access to self-reporting by patients who may not own an at home monitor.
- Patients with asthma were reviewed and offered an asthma management plan. Our searches of patient clinical records found almost all reviews were up to date. We saw that a small number of patients treated with steroids would benefit from a steroid card. The practice recognised there had been some coding issues with those reviews.
- During our clinical system searches we saw, that patients with Chronic Kidney Disease (CKD) stage four or five were mostly being appropriately monitored (CKD is a long-term condition in which the kidneys do not work as well as they should. By measuring the amount of creatinine, a waste product which builds up in kidney disease, the GP can monitor at which stage of the disease the patient was at and how well their kidneys were working). One patient was identified as not having a follow-up and as a result of the searches was to be reviewed by the practice.
- The searches showed not all patients with hypothyroidism (an underactive thyroid gland which can result in tiredness, weight gain and feeling depressed) were monitored. Our clinical searches showed that 786 patients were being treated with Thyroxine (this is a manufactured form of the thyroid hormone thyroxine) and of the 768, 76 patients were not fully monitored in the previous 18 months. Patients had been sent reminders to attend the practice and the monitoring was being reviewed and managed.
- The practice shared clear and accurate information with relevant professionals for care delivery to patients with long-term conditions. For example, community nurses and physiotherapists.
- There was a physiotherapy service for patients at the practice and from outside the area, to support with injury and long-term conditions.
- GPs followed up patients who had received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma or any treatment for long-term conditions. Information was received through the electronic patient record system of patients who had received care, treatment and advice through the out of hours service or the NHS ambulance service. This information was reviewed and followed up by the patient's own GP or duty doctor each day.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 159 | 166 | 95.8% | 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) | 138 | 153 | 90.2% | Met 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 137 | 153 | 89.5% | Below 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 138 | 153 | 90.2% | Met 90% minimum |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 169 | 189 | 89.4% | 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 percentage of children aged two who have received their Immunisation for Hemophilus influenza type b (Hib) and Meningitis C was 85.5%, which was slightly below the 90% World Health Organisation (WHO) minimum target.
- The percentage of children aged five who have received Immunisation for measles, mumps and rubella, was 89.5%, which was slightly below the 90% WHO minimum target.
- The practice followed up on childhood immunisations not attended and provided support and advice for any non-attendance.

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency) | 70.8% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA) | 75.5% | 69.5% | 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) | 72.5% | 70.1% | 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) | 52.5% | 54.9% | 55.4% | No statistical variation |

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

| Any additional evidence or comments |
|---|
| <ul style="list-style-type: none"> The percentage of women eligible for cervical cancer screening who were screened adequately within a specified period was 70.8 %, which was below the 80% minimum uptake level. Staff at the practice told us t an unvalidated current completion rate of 89% had been achieved. During the first lockdown at the end of March 2020 the practice created a waiting list for patients for their cervical smear test during that period. When they were able to start offering face-to-face screening appointments again, they contacted all patients on the waiting list to book them in for their cervical smear test. They gave priority to patients with a previous abnormal cervical smear throughout the pandemic. The practice had a cancer screening coordinator who followed up on non-attendance to ensure screening was offered to all eligible women. |

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

- Audits were ongoing to monitor the quality of the service provided. These audits were both clinical and administrative.
- The practice looked at the appointments available month by month and how they were used. This data was used to develop the service available to patients.
- Clinical audits were ongoing to review the service being provided. For example, cervical smears, vasectomy clinic data, contraceptive data and long-term condition information was audited and used to develop and improve the services available.
- The Cornwall Skin Clinic staff, who are part of the The Spires Medical Practice, audited the service provided by the Cornwall Skin Clinic related to, infection control related and patient satisfaction. The information from this audit was used across the practice.
- The physiotherapy department audited their own practice and supplied data to both the practice GP's and the commissioners of the service. Audit information was used to develop the physiotherapy service.
- Some medicines were routinely audited to ensure compliance with safe practice. These included antibiotics and pain relief medicines.

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 |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Yes |
| <ul style="list-style-type: none"> The provider demonstrated that staff had the right qualifications, skills, knowledge and management support to deliver good quality care and treatment. Staffing levels had been audited and as a result recruitment of staff was ongoing. The practice was proactive in developing new roles to meet demand. For example, a gap in the management team had been identified and the practice was currently recruiting a patient engagement officer. This role was to support with complaints, be responsible for an update of the website, identify opportunities for patient experience surveys and to develop patient and carer involvement to provide meaningful feedback for the practice. The practice had recently signed up to be involved as a training site for student nurse and a further paramedic practitioner had been recruited to make a team of four from October 2022. The Paramedics worked in the on-call duty team alongside the GP's to provide the full range of urgent and on the day care. This helped to meet the rapidly rising demand for on the day patient care. A care co-ordinator had been employed to strengthen multidisciplinary working and coordinate health professionals to meet to discuss complex and involved cases. This helped support the work of the Peninsula Cancer Alliance with GP Practices. The Peninsula Cancer Alliance worked across Devon, Cornwall and the Isles of Scilly, bringing together clinical leaders and patients. This involved looking at the Primary care Network (PCN) data around cancer, including, how many patients had been diagnosed with cancer, what their diagnostic route was and whether there were any learning points. Also, this role included putting together support material for patients living with cancer, highlighting cancer awareness campaigns and cancer screening programs to encourage uptake. Personal development was supported and encouraged with staff supported to complete online training during work hours. If not possible due to capacity of workload, staff could | |

complete training at home and be paid for this. Staff told us they were supported with personal development both financially and with time made available.

- The practice had supported development training for staff to ensure they had the skills to work in the dermatology and vasectomy clinics and theatres. An overview of the dermatology clinics and theatres was maintained by a senior nurse.
- Clinicians were required to maintain their professional registration and demonstrate their competencies when they revalidated with the relevant professional body. The practice monitored their up-to-date registrations to ensure they were registered to practice.

Coordinating care and treatment

Staff worked 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 |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
| <ul style="list-style-type: none"> • The practice managed patients on individual doctors' lists, this was in line with the practice ethos of providing continuity of care. Support was provided by an alternative GP when the doctor was not available. Each of the care homes using the practice had named GPs to ensure continuity of care. • Clinicians followed up the care and treatment of patients following referrals to external services and were involved in multi-disciplinary discussions when needed. • The practice had access to a social prescriber and mental health nurse through the PCN. This enabled easier referrals and ongoing monitoring. | |

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 |
| <ul style="list-style-type: none"> Information was available on the practice website regarding action and support to live healthier lives. Patients with long-term conditions could also access information and support, for example, asthma and heart disease. Information regarding health and wellbeing was also provided to patients during health checks and appointments with clinicians. The GP's maintained their own patient list, this enabled them to follow patients' health journeys, including how they were supported to live healthier lives and any outcomes or changes needed. | |

Consent to care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | 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. ¹ | Yes |
| <ul style="list-style-type: none"> The GP's used opportunities as they presented, to ensure that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were completed. The agreements of care were reviewed as necessary to ensure that the correct legal pathways were created to support patient choice. Remote consultations were not used to assess capacity in adults or children and face-to-face appointments would be made. | |

- Consent was agreed verbally or in written form. Any consent was recorded. The Cornwall Skin Clinic undertook minor operations and we saw consent to procedure was confirmed as part of any procedure. Vasectomy clinics were also provided at the practice and consent was obtained before this procedure.

Access to the service

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

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

| | Y/N/Partial |
|--|-------------|
| Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice | 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 | 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 |
| <ul style="list-style-type: none"> • The needs of the population group had been identified and the practice had adjusted the services it offered to ensure they were accessible, flexible and offered continuity of care. • Extended practice hours had been implemented to enable access for those patients unable to see a doctor during surgery hours. • The practice doctors maintained their own lists of patients. This meant there was mostly consistent access to the same doctor and extended knowledge of each patient. • The location was developing a more accessible working space to enable greater access for patients. | |

Well-led

Rating: Good

Leadership capacity and capability

- The well-led outcome was rated as good at the previous inspection in 2017. At this inspection, the well-led outcome was rated as good. This reflected the ongoing development of the practice with sustained improvement outcomes and the practice's focus on a positive staff culture.
- There was a high level of compassionate, inclusive and effective leadership at all levels. The practice had a clear vision and strategy to provide high-quality sustainable care and had an inclusive culture which valued staff and drove development of the practice. The practice demonstrated a continued and sustained level of development of the service.
- There were clear responsibilities, roles and systems of accountability to support good governance. All staff understood their role and involvement in managing governance. Management had clear and effective processes for managing risks, issues and performance.
- The practice involved the public, staff and external partners to sustain high-quality and sustainable care. There was a strong focus on learning, development and collaboration for individual and service development.

There was a high level of 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 |
| <ul style="list-style-type: none">• Leaders had the experience, capacity and capability needed to deliver sustainable care. The partners were forward-thinking in the development of the practice. The growth, development and sustained success of the GP practice, Cornwall Skin Clinic and the physiotherapy facility evidenced that leadership of the practice could successfully sustain extended services.• The senior management team were experienced in the delivery of GP services, they understood the issues, challenges and priorities of the service. GP's told us that they looked at challenges holistically and gave examples of increased capacity requirements and how this demand was met. A workload survey was undertaken to look at how capacity was met and what level of increased staffing was needed across all staff areas. The practice then began recruiting to exceed the identified level of need.• The partners had managerial and financial responsibility for running the business. There was a business development plan for the ongoing running of the service and developing and expanding to meet demand.• There was an embedded system of leadership, development and succession planning. Staff we spoke with described inclusive and effective leadership at all levels. Staff said they felt supported by the practice partners and management. They described an inclusive working | |

environment which supported them to develop in their roles. Succession planning was ongoing with increased recruitment to all posts.

- The provider had clear management and staffing structures in place, so people understood their roles and responsibilities clearly. Staff were allocated leadership roles which included infection prevention and control, safeguarding and had established effective clinical and non-clinical leaders.

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care. Staff felt involved in the delivery of that strategy.

| | 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 |
| <ul style="list-style-type: none"> • Staff were aware of the providers' vision and felt involved in its development. The objectives identified by the practice were underpinned by a strategy to achieve them. They considered the values and objectives to be challenging but achievable. The strategies were aligned with plans for the wider health economy and there was a commitment to system-wide collaboration to support service development. • Partners told us they had adapted the medical workforce strategy to reflect the increasing pressures of GP workload. This was supported by ongoing medical recruitment and the development of clinical interests and opportunities. • There was a systematic and integrated approach to monitoring and plans for the ongoing practice development were reviewed as part of operational meetings and staff appraisals. There was also a planned strategy workshop which was part of the PCN. | |

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 |
| <ul style="list-style-type: none"> There were high levels of satisfaction across staff we spoke with and from received surveys forms. Staff were proud of the organisation as a place to work and told us they felt valued, included and involved in the practice. The staff we spoke with both before and during the inspection told us they enjoyed attending work and felt supported and motivated to provide a good service. Staff described how they could raise concerns and felt safe to do so. The practice had systems to support the wellbeing and welfare of staff. The practice could access a Freedom to Speak Up Guardian. The business manager operated an open-door policy and staff told us they felt able to raise any issues. We asked staff to complete a Care Quality Commission (CQC) survey prior to our inspection and 14 staff completed these. Staff spoke positively about working at the practice, about being supported and involved and about the positive effects this had for patients. The practice leads told us they were committed to education to staff roles. They told us they encourage a healthy learning culture for staff to help them meet their aspirations and goals thereby creating and encouraging a valued, happy workforce. | |

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

| Source | Feedback |
|------------------------|--|
| CQC staff survey forms | <ul style="list-style-type: none"> We sent staff surveys to the practice prior to the inspection. Staff completed 14 staff surveys before the inspection. Staff told us the practice was a happy place to work. They felt listened to and felt part of a strong and supportive team. Staff we spoke with during inspection were complimentary about the support they received, and they provided examples of when they had |

| | |
|--|---|
| | been supported with learning and development. Some also described the personal support they received when needed. |
|--|---|

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. Staff understood their role in managing good governance.

| | 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 |
| <ul style="list-style-type: none"> • There was a program of continuous clinical assessment and internal auditing which was used to monitor quality and to make improvements. The GP's and business manager met each Friday to discuss any issues and consider developments. There were routine clinical and practice meetings for medical and nursing staff to support the open discussion of issues and cascade learning. Minutes of the meetings were maintained and accessible to relevant staff. Administrative and reception staff met regularly, and minutes recorded the areas discussed and included areas of concern, challenges and plans. • Governance also included complaints and significant events, which were monitored. We saw that each complaint was reviewed and when appropriate actions taken. Incidents were monitored to identify any shortfalls in service provision and ensure action and learning. • The governance structure for the practice included changes being communicated through operational meetings, emails and group discussions. The communication was extended to third parties as needed. • Staff had identified lead roles for example, safeguarding and infection control. Staff were clear about the roles and their own roles and responsibilities. A clinical education afternoon was held to support the learning of trainee staff. • As part of the inspection electronic remote searches we saw some monitoring had not yet been completed. By the time we completed the onsite element of the inspection these shortfalls had already been addressed and systems further embedded to prevent future reoccurrence. | |

Managing risks, issues and performance

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

| | Y/N/Partial |
|---|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | 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. | Yes |
| 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 |
| <ul style="list-style-type: none"> There was a clear culture at the practice for reviewing best practice and monitoring of risk. This was evidenced both through conversations with staff and via documentation. The practice demonstrated performance and risk management systems and processes. Risk assessments were used to monitor and mitigate against any identified risks. Significant events were discussed at practice meetings to review actions taken to prevent reoccurrence. Assurance systems included monitoring of the services provided. For example, there was oversight of medication practices, surgical procedures and infection control procedures. Staff had received appropriate training and monitoring in order to lead on responsibilities about risk oversight. | |

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 |
| Staff were supported to work remotely where applicable. | Yes |
| <ul style="list-style-type: none"> There were recovery plans in place to manage backlogs of activity and delays in routine monitoring and medicine reviews. Data provided demonstrated that the practice was in a good position in most areas of monitored service provision. Backlogs had been caused by the COVID-19 pandemic and there were plans being implemented to address them. For example the diabetic lead nurse was using a tool which highlighted those patients at highest risk for priority monitoring. Each doctor held their own list of patients and so had oversight of which patients in any backlog needed priority monitoring and which patients could be monitored on their birthday month. | |

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 |
| <ul style="list-style-type: none"> The service invested in information systems and processes. For example, the practice had the facility to run data requests to monitor patient call waiting times to establish if there were any delays. Staff were observed to be answering the calls promptly and the practice had not received any complaints about delays in contacting the practice via the telephone. The NHS patient survey for 2022 showed that 85% of patients who responded found it easy to get through to the GP practice by telephone and 60% got to speak to their preferred GP and 98% of those asked found the receptionists to be helpful. These were higher than the national averages. | |

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 |
| <ul style="list-style-type: none"> Information was provided for patients on the practice website on how their personal details were stored securely and how their privacy was maintained. The website detailed how personal data was gathered and what that data would be used for. All electronic equipment was password protected and the reception area faced away from patients. Patient data were stored securely where it was on-site, and other records were stored securely off-site. Consent or agreement was obtained from the patient and recorded to identify their preferred contact method. We saw that paper records were stored securely at the practice, but further security should be considered to limit access to the storage area. Paper records not in use were stored securely off-site. | |

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 |
| <ul style="list-style-type: none"> The practice Patient Participation Group (PPG) had not been active during the COVID-19 pandemic but had a scheduled meeting for October 2022.. There were consistently good levels of constructive engagement with staff and people who use services. The practice used NHS friends and family surveys as feedback. Feedback was assessed and learning implemented where required to improve service quality. In 2022 a GP patients survey was completed. There were 309 surveys sent to patients and 129 were received back, a response rate of 42%. Patients surveyed reported a good overall experience with patients confirming they were happy with how access to the service was managed and the overall appointment experience. | |

- Other surveys of specific services provided, for example, vasectomy services were audited for patients views of the service and satisfaction.
- Prior to the COVID-19 pandemic there had been a PPG at the practice. The group had not met since 2020..There were plans to restart the PPG but at the time of inspection this had not yet taken place.

Feedback from Patient Participation Group.

Feedback

- Prior to March 2020 the practice was involved in the PPG with doctors, staff and patients being represented at meetings. The patient representatives were briefed on developments in the service. Since the COVID-19 pandemic there had only been a short meeting but a further meeting was planned for October 2022.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation. There was a strong focus on learning, development and collaboration for individual and service development.

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Yes |
| Learning was shared effectively and used to make improvements. | Yes |
| <ul style="list-style-type: none"> • The practice had developed a Workload Improvement and Development Group (WIDG). This group comprised of GP's, business manager and reception office manager and was established to address the significant rise in workload since the COVID-19 pandemic. The group took an overarching look at the way the practice worked, with reference to GP workload and appointments. Issues identified were discussed and actions were taken to improve workload for the practice. This remains ongoing and is considered by staff to be a valuable method of identifying and managing workload. • A member of the nursing staff took part in the CARE Programme in 2021. This prompted a project to change the way the practice undertook long-term condition reviews. The project looked at changing the timescale and content of reviews based on risk stratification and identifying patients who needed the long-term condition nurse resources the most, offering different types of reviews based on patient preference and risk factors. This change had been positive and was now being embedded in the service. The nurse involved had shared this learning with other services. • The practice team was forward-thinking and part of local pilot schemes to improve outcomes for patients in the area. One of the the pilot schemes was working with a local group looking at health inequalities and how they could provide the best support available. • There was collaborative working with the other practice in the PCN. Because the service building is shared, some aspects of the computer systems were shared between the two | |

practices. This was positive to ensure that continuous improvement and innovation could be shared. Any shared technology was agreed under a confidentiality policy and service level agreement.

- The practice had GP trainers who provided support and training for trainee medical staff. The practice told us that the ability to recruit and retain was linked to the quality of work they do for medical students and GP Registrars passing through the practice.
- The practice held a subcontract with the local hospital to provide a skin cancer two-week wait, see and treat service which they were able to expand with additional space available.
- The practice had previously implemented a muscular skeletal service. This provided both a spinal interface and hip, knee and shoulder service through the musculoskeletal lead doctor and a dedicated in-house physio team and facility. This service had continued throughout the COVID-19 pandemic and now was looking to return to pre-pandemic capacity.

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.