

# Care Quality Commission

## Inspection Evidence Table

### Central Healthcare (1-5676455770)

Inspection date: 8/9 November 2021

Date of data download: 20 October 2021

At the October 2020 inspection Central Healthcare was given a rating of requires improvement; a move from the previous rating of inadequate. It was acknowledged at the time of the inspection that the practice was on an improvement trajectory and had worked hard during the COVID-19 pandemic to improve in many areas. However, some newly implemented systems and processes to support the safety of patients and the governance of the practice were not sufficiently embedded to provide assurance that the systems provided effective oversight and delivery of safe care.

At this inspection in November 2021 we found the practice had moved from a rating of requires improvement to a rating of good. The provider had addressed the previously identified issues for improvement and demonstrated over the longer term that the changes had been embedded and sustained. This resulted in improved systems and processes to support the safety of patients and effective oversight and delivery of safe care and governance at the practice.

**Overall rating: Good**

**Safe**

**Rating: Good**

At the October 2020 inspection Central Healthcare was rated as requiring improvement for providing safe services. Improvements had been made regarding infection prevention and control,

safeguarding, medical emergencies, significant events, recruitment and the monitoring of prescription stationery. However, we identified issues relating to the safe monitoring of patients on high risk medicines that required improvement.

At this inspection we have rated Safe as good. Further improvements had been regarding the safe monitoring of patients on high risk medicines, infection control and prevention, recruitment of staff and the monitoring of prescription stationery.

## Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• All staff had received safeguarding training to the required level for their role. Clinical staff were trained to level 3 and non-clinical staff to level two.</li> <li>• The safeguarding leads facilitated regular updates for staff. The team was led by a nominated GP supported by a deputy GP, nurse and administration lead.</li> <li>• Monthly safeguarding meetings took place and were joined by staff from health and social care. We saw examples where appropriate action was taken in relation to safeguarding concerns. Reports were produced regularly by the lead or their deputy.</li> <li>• The safeguarding policies and procedures had been reviewed and updated.</li> <li>• The practice demonstrated they had assurance that all required staff had a Disclosure and Barring Service (DBS) check in place before employment commenced.</li> <li>• The practice used 'family of concern' codes to identify families on the safeguarding register.</li> <li>• The practice regularly liaised with the safeguarding leads from across the Haxby group to look at policies and share learning.</li> </ul>	

Recruitment systems	Y/N/Partial
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Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The recruitment and selection policy had been reviewed and updated.</li> <li>The practice had developed a robust process for checking and monitoring locum staff.</li> <li>Enhanced arrangements had been put in place to ensure staff were recruited safely and that appropriate records kept reflected best practice.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: August 2021	Y
There was a fire procedure. Date of fire risk assessment:7/9/2021	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Health and safety monthly meetings took place with detailed minutes and actions identified/taken to mitigate risk. We saw a range of risk assessments such as COVID-19 and Control of Substance Hazardous to Health (COSHH) were in place.</li> <li>The practice identified and addressed actions following the fire risk assessment for Lawrence House and Peasolme surgery. Examples of these included the replacement of the fire location screen in Lawrence House and increasing the number of trained fire wardens across sites.</li> <li>The practice has risk assessed the evacuation process for Lawrence House and fire wardens were trained to check all areas in the event of evacuation.</li> </ul>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:06/2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

- The practice undertook a range of IPC (infection prevention and control) monitoring such as weekly checks, monthly audits of the environment, aseptic technique, hand washing and environment spot checks. Where issues for improvement were identified immediate action was taken to remedy them.
- We saw that domestic staff also received training in IPC and were regularly monitored.
- The practice had in place an IPC team and nominated lead. The team worked jointly across the group of practices to ensure joint learning and shared policies. Following the refurbishment of Lawrence House all the treatment and consultant room layouts were the same and streamlined.

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Systems and processes were in place to monitor staff absence and service demand. The practice constantly reviewed absence planning, risk assessing the day before when possible to ensure adequate staffing arrangements were in place.</li> <li>• The practice used a 'WhatsApp' group to contact a nominated group of managers and staff to support the practice during busy periods. WhatsApp is a messaging app that lets users' text and communicate including voice messages and video, with individuals or groups.</li> <li>• The practice had introduced the Operational Pressures Escalation Levels Framework (OPEL). This is a method used by the NHS to measure the stress, demand and pressure a service is under with the Clinical Commissioning Group (CCG) and local services and to gain appropriate support when the service reaches OPEL 3 which is the highest level in primary care.</li> <li>• The practice had introduced a new induction pack and support process for new staff. There were similar processes in place for locum staff.</li> <li>• Appropriate arrangements were in place for managing and responding to medical emergencies. For example, staff had completed basic life support and anaphylaxis training and had access to emergency equipment in accordance with national guidance.</li> </ul>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was evidence of referrals being made appropriately in patients records and these were regularly monitored. Any learning identified was actioned and the effectiveness monitored.</li> <li>• A process was in place to continually monitor and action the number of patient records waiting to be summarised.</li> <li>• There was a process in place to ensure the safe and effective management of test results. Audits were regularly undertaken.</li> <li>• We looked at some patient records who are prescribed Disease-Modifying Antirheumatic Drugs (DMARDs) These are a group of medicines commonly used in people with rheumatoid arthritis. We saw in the patients records that all blood tests were actioned appropriately.</li> <li>• The practice had introduced a new task protocol with the aim of preventing urgent messages and information being missed. The effectiveness of the process was regularly monitored with staff running regular searches of unactioned tasks and action taken to address these.</li> <li>• All staff had completed Information Governance and General Data Protection Regulation (GDPR) training.</li> </ul>	

## Appropriate and safe use of medicines

### The practice had 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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.81	0.72	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	4.0%	8.1%	10.0%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	5.34	5.15	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	168.6‰	131.3‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.57	0.53	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	7.8‰	4.6‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Not looked at No CDs kept on premises
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<ul style="list-style-type: none"> <li>• There was a process in place for the safe management of prescription stationery. Currently 98% of prescriptions were now sent electronically to the patients nominated pharmacy. All printers in the clinical rooms were locked with a limited amount of paper prescriptions, a record was kept of serial numbers in each printer. Only the practice pharmacist and the medicines optimisation manager had access to the prescription stores.</li> <li>• Appropriate safeguards were in place to support the safe ordering of medicines. The pharmacy team monitored this and the prescribing of medicines that had the potential to be misused. The practice was currently working on a project to reduce the use of opioids in the practice.</li> <li>• Systems were in place to monitor repeat prescribing.</li> <li>• Patients mainly ordered repeat prescriptions electronically but still had the option to telephone or write to the practice to request a repeat prescription if needed.</li> <li>• The practice had engaged a private pharmacy service which is a company providing off site support with medicine reviews and reauthorisation. The practice pharmacist reviewed the process and sampled reviews undertaken by the service for quality control. The private service</li> </ul>	



Medicines management	Y/N/Partial
<p>had access to the surgeries clinical systems and could check whether monitoring was in place and up to date. Any queries or out of date monitoring would be highlighted for action by the lead pharmacist.</p> <ul style="list-style-type: none"> <li>• The practice was working towards 'proxy ordering'. This is a process that allows care homes to set up a process with the practice which will enable care home staff to order repeat medications on behalf of their residents</li> <li>• We saw appropriate arrangements were in place for the management of emergency medicines.</li> <li>• The practice had a program of regular audit in place that included searches of Medicines and Healthcare products Regulatory Agency (MHRA) guidance and alerts and patients on high risk medicines to ensure prescribing was in line with national guidance. The lead pharmacist produced a regular newsletter of audits undertaken and the learning identified for action.</li> <li>• Appropriate arrangements were in place to monitor and manage refrigerator temperatures.</li> </ul>	

### Track record on safety and lessons learned and improvements made

#### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	39 Administration 79 Clinical
Number of events that required action:	All
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Significant events (SEAs) were divided into clinical and administration significant events.</li> <li>• The practice had acted to improve the management of significant events (SEA). Areas of improvement included updating the policies and processes, training for staff and the recording of SEAs. However, we saw that some of this information had not been detailed on some of the records we looked at. For example, the name of the person responsible for monitoring actions, the review of actions and date for review. During the inspection the practice shared with us an improved SEA process which was due to commence within the next month. Training for this new process had been arranged.</li> <li>• Meetings to review SEAs were held weekly with the clinical and administration support officer to review all outstanding SEAs and agree actions and monitor progress. This was followed by monthly clinical meetings led by the clinical lead and nominated staff.</li> <li>• The practice had developed a new system to share learning from SEAs and complaints with all staff. Following staff feedback shared with us during the inspection the practice told us they will now identify if the learning was from a SEA or a complaint.</li> </ul>	



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

Event	Specific action taken
Delay in issuing a death certificate	<ul style="list-style-type: none"> <li>• Re-circulation of the death administration protocol to all staff.</li> <li>• All deaths were added as home visits to ensure they were dealt with by the GP of the day if the patients normal GP was not available.</li> <li>• Shared on 'Remember to' newsletter to ensure learning from the incident was communicated to all staff.</li> </ul>
Child invited to COVID-19 vaccination clinic for 12-15-year olds based on read coding that was on the wrong patients record.	<ul style="list-style-type: none"> <li>• Review of the read coding within the practice and process in place to prevent re-occurrence introduced.</li> <li>• Shared on 'Remember to' newsletter to ensure learning from the incident was communicated to all staff.</li> </ul>

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

Explanation of any answers and additional evidence:

- There was a nominated lead working with the business intelligence team to review and disseminate all safety alerts across the practice. The actions were recorded and reviewed monthly.



# Effective

# Rating: Good

At the October 2020 inspection Central Healthcare was rated good for effective. At this inspection the rating remains good.

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

## Effective needs assessment, care and treatment

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

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

## Effective care for the practice population

Findings
<ul style="list-style-type: none"><li>• 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.</li><li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li><li>• Flu, shingles, pneumonia and COVID-19 vaccinations were offered to relevant patients in this age group.</li></ul>

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The care home staff were being trained by the specialist care home nurse and encouraged to use the SBAR (Situation-Background-Assessment-Recommendation) technique which provide a framework for communication between members of the health care team about a patient's condition to try and improve care management.
- The care homes were provided with a nurse link who supported the care home staff. We spoke with the managers from two care homes. They told us they were well supported by the clinical staff from the practice.
- All patients with a learning disability were offered an annual health check. There was a nominated GP and nurse lead for learning disabilities.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The clinical searches identified a backlog of some long-term condition reviews. For example, we looked at the records of five patients with a diabetic diagnosis. We saw that none of these patients had a recorded review. We were told that the practice would review this group of patients and proactively offer patients a diabetic review if required. And, those patients with a diabetic complication such as retinopathy or those patients who were clinically vulnerable from covid would be prioritised.
- The practice had introduced a process to identify those patients with complex needs first for review and where possible with the less complex patients to conduct reviews over the telephone and then followed up with blood tests when required. The practice was confident that the plans introduced would address delays in any reviews for long term conditions. Following the clinical searches carried out as part of the inspection, we received further assurance that the programme was underway and continually monitored.

- We saw that the practice was providing advanced training for health care assistants to assist with reviews.
- The practice had implemented COVID-19 pulse oximetry (oxygen is carried around in your red blood cells by a molecule called haemoglobin. Pulse oximetry measures how much oxygen the haemoglobin in your blood is carrying), at home monitoring for high-risk patients.
- The practice used signposting to social prescribers. Social Prescribers are staff who undertake an assessment of what care and support people need, such as physical activities, learning new skills, making new friends or finding employment.
- Alerts were placed on patient records making it easier to identify palliative care patients.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- The practice has implemented BP@Home programme to proactively engage patients with hypertension. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. The practice was part of a national and local initiative to identify and treat patients with hypertension using assistive technology and home monitoring.
- Patients with chronic obstructive pulmonary disease (COPD) were offered rescue packs.

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) (01/04/2019 to 31/03/2020) (NHS England)	225	242	93.0%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	279	297	93.9%	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) (01/04/2019 to 31/03/2020) (NHS England)	277	297	93.3%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	280	297	94.3%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	277	307	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>

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/03/2021) (Public Health England)	71.2%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	73.6%	76.5%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	62.7%	68.7%	63.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	51.3%	54.1%	54.2%	No statistical variation

#### Any additional evidence or comments

- The practice shared unverified cervical screening data, up to the current date the practice demonstrated they were on track to meet national targets in both age ranges and were currently at 89%.
- The provider had put in place a range of measures to improve the uptake of cervical screening. They had increased the number of staff trained in cervical screening.
- At the last inspection the practice had identified several foreign nationals who had not engaged with the practice they were able to send out translated letters and were possible phone the patient inviting them for screening.
- The practice started to recall patients using letters and calls to reassure patients it was safe to attend the practice for this procedure during COVID -19.
- The practice had appointed a lead GP for cancer. All missed cancer diagnosis were investigated as a significant event. The practice shared unverified bowel cancer screen data for 60 to 74 year old showing they were currently at 80%. The practice also shared initiatives that they had introduced to address the previous shortfall, such as improving communication, coding and running monthly searches to identify non-attenders for annual reviews and health monitoring.
- The practice regularly contacted patients asking how they were coping following their diagnosis and if they would like an appointment with a GP.
- We saw that the practice had introduced regular audits to monitor two-week referral rates (this is a request from the GP to ask the hospital for an urgent appointment because the patient may have symptoms that might indicate cancer) and monitor the process to ensure its effectiveness.



## Monitoring care and treatment

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

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

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

An audit was undertaken to review patients with a high HbA1c (this is a test used to look at your average blood sugar and to identify the risk of developing diabetes) who had not been diagnosed with type two diabetes. The audit identified areas for improvement which were acted on. These actions included a regular audit of reviews introduced, recall codes added to patients notes to ensure there was continual monitoring and a process to ensure abnormal results were not filed without action.

An audit had been undertaken looking at retrospective data of early cancer diagnosis. The practice looked at suspected cancer referrals (known as "two week waits" (2WW)) and to look at all those diagnosed who were then diagnosed with cancer. Of the 58 patients identified as those referred on the two weeks wait, two were duplicates leaving 56 referrals. Eight patients from this list were diagnosed with cancer – giving a conversion rate of 14%. However, of the eight cancers found, four were already known to have cancer giving a conversion rate of 7.4%. This identified the need to increase the number of cancer referrals. The practice introduced several actions. These included continued work with the primary care network on early cancer diagnosis, promoting the use of the suspected cancer referral guidelines, promoted learning for staff, an analysis of patients diagnosed with cancer via the emergency route, and undertake SEA on the cases where learning could be identified.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice supported staff with ongoing training and regularly monitored training. For example, two practice nurses had been supported to undertaking the Advanced Care Practitioner (ACP) course. The practice was a training site for the new nurse training in the town and recently welcomed two newly qualified nurses to the team.</li> <li>• The practice was a training site for medical students and GP training.</li> <li>• The pharmacy team was supported by a nominated GP, lead pharmacist and medicines optimisation lead.</li> <li>• At our last inspection the practice had identified training to train department leads to undertake staff appraisal. At this inspection we saw all staff reported having received an annual appraisal and we received information confirming this.</li> <li>• The staff told us they were supported constantly within the practice and by staff from across the Haxby group. There was opportunity for shared learning and support across all practices in the group.</li> <li>• The practice had introduced and embedded clinical group supervision for the nursing team.</li> </ul>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The continuity of seeing the same clinician had been hindered by the COVID-19 pandemic. Despite this, where possible the practice was trying to ensure that patients outside of an emergency were able to see the same clinician particularly when treating ongoing conditions.</li> <li>• The practice had introduced a new telephone and online patient flow management software to assess and direct patients to the right point of care. We were told by the practice there were some initial problems encountered by patients in the beginning which now seem to have settled. However, the patient participation group member we spoke with told us some patients struggle with the new process.</li> <li>• The practice had established several different clinical leads. For example, cancer and frailty lead to assist in the care of these patient groups.</li> <li>• There were several changes within the practice with new members of staff and staff leaving the service. The practice was being supported during these periods by staff from across the Haxby group. The practice was currently 10% short of their long-term target of the number of GP sessions they were aiming to deliver.</li> <li>• The practice informed us that they have five new GP fellowships commencing in February 2022 working across the Haxby group. The General Practice Fellowship is an NHS England funded 2-year programme of support for newly qualified GPs.</li> </ul>	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	
<p>We saw the practice were involved actively in health promotion. Examples of this were evidence of lipid profile bloods checked to manage cardiovascular risks and HBA1C bloods checked to manage patients who were at risks of developing diabetes.</p> <p>The practice had a process in place for reviewing patients with learning disabilities (LD) and a clinical lead had been appointed to manage this. During the inspection the practice provided unverified information that to date 79 of the eligible 178 patients had been reviewed and a further nine booked. The practice had implemented a range of initiatives with the LD lead to improve uptake. Reviews would be arranged at the month of birth, there would be a focus on screening, and the lead would undertake telephone invitations offering suitable time and quieter environment.</p>	

## Consent to care and treatment

### The practice always obtained to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: There was evidence of active discussions with patients being documented in the patients notes.	

## Caring

## Rating: Caring

At the October 2020 inspection Central Healthcare was rated good for Caring. At this inspection the rating remains good.

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• At this inspection we did not speak directly to patients other than the Patient Participation Group (PPG) due to COVID-19 restrictions. The PPG representatives told us they were happy with the care and support they had received from staff.</li><li>• Over the past year we have been contacted by a large number of patients who were unhappy with the access and care provided by the service. When we contacted the practice, they were proactive in contacting the patients to address the issue and improve services were possible.</li></ul>	

Patient feedback	
Source	Feedback
PPG	Overall staff were friendly, caring, polite, good and helpful. They told us the practice tried to keep them informed about changes and developments in the practice. They felt they were listened too when they raised issues. They told us they found the staff in the practice caring and responsive.
Care Home staff	We spoke with the managers of two care homes. They told us they were happy with the service provided by the practice. They were positive about the care and support the patients and staff received. However, they did comment that sometimes they encountered difficulties contacting the practice and occasional poor attitude of non-clinical staff.





## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	81.6%	92.5%	89.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	84.9%	91.8%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	95.0%	97.3%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	64.7%	88.9%	83.0%	Variation (negative)

### Any additional evidence or comments

Following the results of the patient survey the practice had implemented initiatives to improve patient experience:

- The practice had implemented a number of initiatives to improve the overall experience of attending the practice. Examples included a new telephone system and online consultation services.
- Improvement of the environment in Lawrence House with a complete renovation.
- The practice had implemented a process for learning from complaints and significant events.
- Following the results of the patient satisfaction survey the practice had produced posters and newsletter to explain to the patients how they had responded to the survey.

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

### Any additional evidence

- We saw examples of two surveys completed regarding the COVID–19 clinics offered by the practice; the feedback was predominantly positive.
- The practice were currently undertaking a patient survey about the branch surgery at Tennyson Avenue. There were concerns from the practice about the condition of the building and its suitability for use by both patients and staff.

## Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	91.4%	95.8%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We saw that there was a range of information to help patients available on the practice website such as treating infection, patient confidentiality, accessing data and an A to Z of health.</li> <li>Five different languages were spoken by GPs at the practice.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	On the 1/9/2021 there were 736 registered carers which is 2.6% of the practice population.
How the practice supported carers (including young carers).	<p>The practice had a process to ensure carers were identified and received the right support and care.</p> <p>Identify carers and cared for patients on care records and ensure they are linked under relationships.</p> <p>Provide regular health checks and recall for carers.</p> <p>Offer COVID-19 and flu vaccines.</p> <p>Identify and support more young carers. The practice currently had eight young carers registered.</p> <p>During October/November 2021 the practice was undertaking engagement work with carers to improve their processes and support carers.</p>
How the practice supported recently bereaved patients.	Bereavement support services were advertised on the practice website and within the practice.

## Privacy and dignity

**The practice respected patients' privacy and dignity.**

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

## Responsive

## Rating: Good

At the October 2020 inspection Central Healthcare was given a rating of requires improvement for responsive;

This is because:

- Both clinical and non-clinical staff reported concerns that there were not enough staff to allow them to carry out their roles effectively.
- Whilst we saw that some systems were being introduced into the practice to manage patients access to care and treatment these were not fully embedded and overall access to appointments for patients remained difficult and services did not always meet patients' needs.

At this inspection November 2021 we saw that there had been improvement and we have rated them good. Since the partnership with Haxby Group the practice had been supported by staff from the group providing extra clinical and non-clinical staff. Staffing remains an issue however, we saw processes in place to improve staffing.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• In response to COVID-19 the provider implemented a plan to deliver services working closely with the CCG and the Scarborough Core Primary Care Network (SCORE).</li><li>• The practice recently started to house several administration staff in York House (previously occupied by the CCG) as a temporary measure during the refurbishment of Lawrence House.</li><li>• The service was now delivered from two sites; Lawrence House and Peasholm Surgery following the closure of Prospect Road surgery.</li></ul>	

- The practice produced regular newsletters/briefings to keep staff and patients informed of the changes and developments. We saw that there were regular staff meetings and briefings with staff.

<b>Practice Opening Times</b>	
<b>Day</b>	<b>Time</b>
<b>Lawrence House</b>	
Opening times:	
Monday	7:30am - 8am extended hours 8am - 6pm usual hours. 6 pm – 8 pm extended hours
Tuesday	7:30am - 8am extended hours 8am - 6pm usual hours
Wednesday	7:30am - 8am extended hours 8am - 6pm usual hours 6pm – 8 pm extended hours
Thursday	7:30am - 8am extended hours 8am - 6pm usual hours 6 pm – 8 pm extended hours
Friday	8am - 6pm usual hours 6.30 – 8pm when needed for extended access
Appointments available:	
Monday	7:30 am - 8am extended hours 8am – 6pm usual hours 6pm – 8pm –extended hours
Tuesday	7:30am - 8:am extended hours 8:am – 6pm usual hours
Wednesday	7:30am - 8:15am -5:40pm 8am extended hours, 8am – 6pm usual hours, 6:30pm – 8pm extended hours
Thursday	7:30am - 8am extended hours 8am – 6pm usual hours 6.30pm – 8pm extended hours
Friday	8am - 8pm usual hours 6:30pm – 8pm when needed for extended access
Practice Opening Times – Peasholm	
Monday	8am– 6pm
Tuesday	8am– 6pm
Wednesday	8am– 6pm
Thursday	8am– 6pm
Friday	8am– 6pm
Appointments	



Monday	8:15am -5:40pm
Tuesday	8:15am -5:40pm
Wednesday	8:15am -5:40pm
Thursday	8:15am -5:40pm
Friday	8:15am -5:40pm

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

- Patients had a named GP who supported them in whatever setting they lived. However, due to current demands on staffing this was sometimes difficult.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. The practice had in place a process to support patients and staff in care homes.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Patients were able to self-refer to the mental health crisis team. Staff in the access team were able to provide this telephone number to patients who required this service.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice provided extended hours opening as listed above.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travelers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travelers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability offering appointments at quieter times to suit the needs of the patient.

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

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	24.1%	N/A	67.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	47.4%	78.3%	70.6%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	39.3%	72.6%	67.0%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	67.6%	86.0%	81.7%	Variation (negative)

- The practice was aware of the performance in the National GP Patient Survey and had been taking steps to address the concerns around access. We saw that a new telephone system had been installed with the aim of reducing waiting times when calling the practice, and more staff had been deployed to answer calls during busy periods.
- Online consultations had been implemented in March 2021 which allowed requests for appointments to be made.
- Appointments were available with GPs, advanced care practitioners, physiotherapists and pharmacists.
- The practice informed us that they have five new GP fellowships commencing in February 2022 working across the Haxby group. The General Practice Fellowship is an NHS England funded 2-year programme of support for newly qualified GPs.

Source	Feedback
For example, NHS Choices	Eleven reviews had been received between Oct 2020 and October 2021, seven were rated one-star, one two-stars, two four star and one five stars. The one-star issues related to waiting times to get through to the practice on the telephone, issues getting a prescription, and, being told by the practice that they will ring back

	<p>and not receiving a call. The two-star rating related to a patient unhappy that following a telephone follow-up consultation they were told to attend A&amp;E. The four and five-star commented that their experience of Central Healthcare has been excellent, and the staff were caring, friendly and provided explanations. We saw that the practice had not responded to any of these comments.</p>
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## Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	89 Administration Complaint  196 Clinical Complaints
Number of complaints we examined.	Five
Number of complaints we examined that were satisfactorily handled in a timely way.	Five
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	one

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice was aware of the large number of complaints they had received and encouraged patients to raise issues. They proactively contacted the complainant, listening, investigating and identifying learning.</li> <li>Complaints were rated using a Red/Amber/Green (RAG) rating, from red being high and green low risk. The main themes from the complaints identified were, difficulties getting an appointment, length of time waiting for an appointment, prescription issues, phone queuing, reception attitude and continuity of care.</li> <li>As part of CQCs role we receive information from patients which we consider as part of the inspection process. In the last year some patients have contacted CQC to raise concerns, some of which are relating to their care, access to appointments and the attitude of some clinical and reception staff. The practice had been made aware of these (with the permission of the patient) and investigated the issues raised.</li> <li>We saw the complaints procedure and how complaints were handled had been reviewed several times since our previous inspection to improve governance arrangements. We saw evidence that the practice now contacts the complainant via the telephone to discuss the complaint with an aim of providing a more individual and person-centered response. The practice was also monitoring complaints to look at trends and themes.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Unable to access an appointment for cervical smears	The practice increased the number and timing of appointments. They have increased the number staff able to undertake this process and were also supported by staff from across the Haxby group of practices.
Difficulties obtaining Fit note and fit note not signed not signed	Staff alerted to the policy and process to ensure fit notes were dealt with in a timely manner.

## Well-led

## Rating: Good

At the October 2020 inspection Central Healthcare was rated good for Well-led. At this inspection the rating remains good.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had initiated a Governance and Partnership Board (GPB) to monitor all developments and governance.</li><li>• The practice was working effectively as part of the Haxby Group with a shared leadership and governance structure. The practice shared support for management, leadership, training, the sharing of some staff, policies and procedures.</li><li>• Staff told us they were supported and worked effectively with all staff. They commented they received on-going support and the opportunity to share experience and development.</li><li>• The practice has appointed departmental leads who reported into the governance board and provided support to staff.</li><li>• There was a clear leadership and development structure in place.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice was in the process of rebranding and from the 1st December 2021 would be known as Haxby Scarborough.</li></ul>	



- The practice held an away day for all staff to discuss future developments, celebrate achievements and focus on the vision and values of the practice, moving forward.

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We saw there were clear improvements since our last inspection in terms of managing and responding to behavior inconsistent with the practice's strategy. The practice had identified areas of concern and implemented strategies to continually review and implement services and structures to improve.</li> </ul>	

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

Source	Feedback
Non-clinical staff	We received 30 completed questionnaires from non-clinical staff. Staff told us that they felt supported by their manager and worked well as a team. Staff discussed the difficulties and changes over the past few years such as COVID - 19, practice mergers, patient comments and the CQC inspection process. Staff told us they felt supported by the team and was positive about the practice. They told us that they had clear roles and responsibility. Staff knew how to manage and deal with emergencies and had received appropriate training in the management of emergencies. They reported having access to appraisal and supervision. Staff told us that they understood there were ongoing issues with staffing and understood the difficulties in attracting staff to area. They told us about recent recruitment drives but felt it remained an issue recruiting and retaining staff. The practice had introduced initiatives to move staff to help during emergencies. However, some staff were concerned this was taking them away from their work and finding time catch up with their work was difficult. The majority of staff commented on enjoying working at the practice and being welcomed.

Clinical staff	We received 14 completed questionnaires and spoke with ten members of staff. Most staff reported they worked well as a team and were positive about the joining with Haxby Group. Staff told us they had access to training and support from their managers. They told us due to work constraints attending meetings was often difficult. Staff commented about recent staff changes and the ongoing difficulties to recruit. They commented that staff cover was difficult during COVID-19 due to limited availability of staff and staff leaving or retiring. The nurses told us that supervision was now taking place. However, they also said they would like the opportunity to attend other meetings such as significant event meetings and briefings and other meetings possibly on a rotational basis. Staff were positive about moving forward in the new organisation and felt the changes had been positive.
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## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice shared with us the governance structure in place across the Haxby group partnership. The governance and partnership board monitored the progress of the developments and operational performance.</li> <li>• Responsibility, accountability and operational management was shared across various leads within the organisation.</li> <li>• There was an ongoing process of audit and monitoring across the organisation to help the process of identifying gaps in governance.</li> <li>• The practice had continued to address previous areas of concern to show improvement seeing new roles and systems being put in place to promote good governance and management</li> </ul>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice undertook regular audits to ensure compliance with training and to identify training requirements of the practice. However, one or two staff stated they had not completed all the required training. The reason for this was not explained however most of the training was available to access on an online training package.</li> <li>• We saw that team leaders had been trained in the management and monitoring of staff and annual reviews.</li> <li>• The practice was using a number of regular locum staff. We saw the practice had introduced processes to monitor and support these staff ensuring policies and processes were adhered to.</li> </ul>	

**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.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y

Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice employed and trained care navigators' who were part of the access team. This was the first point of contact for patients when the phone was answered. They worked closely with the triage lead, online triage system to signpost patients to the appropriate service. However, we still saw that not all patients were happy with this process.</p>	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

## Governance and oversight of remote services

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

## Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>The practice was working hard to maintain and develop the PPG further within the practice. They had refreshed the online membership to establish who from the group wanted to remain. They had developed a core group of twelve members who were meeting regularly with the general manager. The group had plans to encourage patient feedback further holding promotion days in practice. The PPG also attended virtual meetings with the CCG which they found useful.</p> <p>Staff reported they were able to express their views and were listened to. We saw that the practice used SEAs, formal and informal complaints to listen to patients, identify themes and implement actions to improve the service experience.</p>	

### Feedback from Patient Participation Group.

Feedback
<p>We spoke with two members of the patient participation group (PPG), who were positive about the improvements within the practice. Improvements ranged from the refurbishment of Lawrence House which they found impressive and clean, the new telephone system, the online access system, the joining with Haxby Group, learning from complaints and the proactive approach of staff to improve patient services. The also commented that this was a work in process and such developments like the telephone system took some time to become embedded. They told us that developments and future for the service were shared and they felt empowered to speak with other patients.</p>

## 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.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
There is now an embedded process for audits across the practice and Haxby group. There were learning plans established for the year to identify issues that needed to be addressed.	
We saw that the practice had reviewed their systems and processes and were working through their improvement plan.	
The practice was currently involved in the training of student nurse, medical students, registrars and international GPs.	
We saw examples of the practice continually developing their services. Examples of these were the GP fellowships and the development of the menopause friendly service.	

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of 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.
- **PHE:** Public Health England.
- **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.
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- ‰ = per thousand.

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