

Care Quality Commission

Inspection Evidence Table

Wensum Valley Medical Practice West Earlham Health Centre (1-544402109)

Inspection date: 3 November 2022

Date of data download: 19 October 2022

Overall rating: Requires Improvement

We previously carried out an announced comprehensive inspection at the practice on 1 March 2022. The practice was rated as inadequate overall and placed into special measures. As a result of the concerns identified, we issued the practice with a warning notice relating to a breach of regulation requiring them to achieve compliance with the regulation by 15 June 2022. We undertook a focused review on 27 June 2022 to check that the practice had addressed the issues in the warning notice, and we found they had met the legal requirements.

At the last inspection on 1 March 2022, the practice was rated as Inadequate overall and specifically for providing safe and well-led services. The practice was rated as Requires Improvement for providing effective services and Good for providing caring and responsive services. This was because:

- There was a lack of clinical oversight in areas which impacted on safe and effective patient care.
- There were ineffective systems in place to learn and make improvements when things went wrong.
- There were gaps across practice systems to support safe, effective and well-led services.
- The provider could not demonstrate a clear practice vision. The governance and lines of accountability within the practice were not always clear.
- There was a lack of evidence to demonstrate active patient, public and staff engagement.
- There was some evidence of low morale at the practice and evidence of a closed culture at times.

At this inspection, the practice is rated overall as Requires Improvement because;

- The practice and leaders had been fully engaged with the external support provided by the Integrated Care Board (ICB). They were working to a clear action plan and had made improvements. These improvements had been newly established and required further time to be fully implemented, embedded and monitored to ensure improvements would be sustained.
- The clinical oversight had been improved and increased and the leaders had greater awareness of their responsibilities in driving and monitoring the improvements needed.

They had developed a new management structure which needed to be embedded to ensure safe and effective services were delivered.

- A governance framework had been strengthened to identify and manage gaps or actions required that had been identified through risk assessments.
- There continued to be evidence of low morale at the practice and evidence of a closed culture at times. However, some staff told us this had started to improve.
- Although the practice had made improvements, these had not been wholly implemented as there had not been sufficient time to demonstrate effectiveness. There were gaps across practice systems to support safe, effective and well-led services.
- The practice was reliant on external support staff to address all the issues and implement changes. The practice was in the process of recruiting new staff.

Safe

Rating: Requires Improvement

At the last inspection on 1 March 2022, the practice was rated as inadequate for providing safe services because evidence highlighted a lack of clinical oversight and ineffective safety netting across systems and processes to support safe care. In particular:

- The practice did not have an effective system in place to learn and make improvements when things went wrong.
- There were gaps across the practice's systems and processes to support safe use of medicines.
- The practice's system for managing test results was not always effective, resulting in instances where test results were not managed in a timely manner.
- The practice did not operate an effective system for managing medicines safety alerts.

At this inspection we have rated the practice as Requires Improvement for providing safe services because;

- Although improvements had been demonstrated, the practice system in place to learn and make improvements when things went wrong was not wholly effective.
- Although improvements had been demonstrated, the practice system in place to support the safe use of medicines required further implementation and patients' reviews.
- The practice had not fully reviewed their recruitment system and processes to ensure they could demonstrate that all staff were recruited safely.
- The practice systems and processes to manage risk assessments such as fire safety had not been managed safely.
- Not all nursing staff were trained to safeguarding children level 3 and prior to the inspection the practice had not identified the need.

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.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes ¹
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: 1. The practice told us that all the nursing team were trained to level 2 child protection training, but they had booked all nursing staff onto a course in December to attain the required level 3 safeguarding training.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence: 1. At our last inspection, March 2022, we noted that the practice demonstrated they had some systems and processes to ensure staff were recruited safely but we found that not all staff had undergone a DBS check at the appropriate time. At this inspection, the practice showed evidence that new staff they had employed had undergone a DBS check appropriately. However, we found some staff records were held in paper form and electronic records and the practice could not evidence all recruitment documents for some staff were in place. The practice did not evidence they had a system to ensure staff professional registrations were checked at time of recruitment or on a regular basis.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 19 October 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: West Earlham site 30 October 2021- unreported assessment October 2022 Bates Green site 30 October 2021- unreported assessment October 2022 Adelaide Street site, this property is not owned by the provider, during the inspection the practice obtained a copy of the property's fire risk assessment. Actions from the fire risk assessment were identified however, not all completed or associated risk assessments were in place.	

Explanation of any answers and additional evidence:

At our last inspection, March 2022, we noted that at the main practice site at West Earlham Health Centre, some actions from the practice's fire risk assessment had been identified but were yet to be completed. The practice told us that due to a change in the management responsibility of managing risk assessments, they had reviewed the previous assessment and had decided to repeat them. They engaged the same external company to ensure the most up to date information was available. The assessments had been undertaken in October 2022 and the practice was awaiting the reports.

Staff said that they carried out weekly fire alarm testing and recently had a fire drill at the practice West Earlham site, however staff at the Bates Green site told us they had not undertaken a fire drill in the past 12 months.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: All three sites October 2022	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
Explanation of any answers and additional evidence: The practice had improved their oversight to ensure infection prevention and control was managed safely. The lead nurse undertook regular checks and engaged with staff to keep them updated with any changes.	

Risks to patients

There were gaps in 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.	Partial ¹
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	No ²
Explanation of any answers and additional evidence: 1&2. The practice recognised that they were experiencing challenges in staff retention which had a negative impact on their approach to managing staff absence and busy periods. The practice was actively recruiting new staff and had been successful in recruiting some new staff including an additional	

partner. Staff we spoke with or had feedback from, told us that the high workload and poor communication/attitude from the leaders and newly formed management team both contributed to poor retention and low morale. They told us that there were signs of leaders taking more responsibility but reported improvements were still needed, in particular to feedback when issues were raised. Staff told us that the staff shortages resulted in them undertaking additional work and/or working with insufficient time to ensure all tasks were completed fully and safely. We discussed this with the partners who were aware of the low morale of some staff and told us they were working hard to change this. The practice had undertaken some exit interviews to understand the improvements needed to retain staff. They had been successful in recruiting some new staff but still required more staff.

Information to deliver safe care and treatment

Staff did not have all 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	Partial ¹
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial ²
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 ³
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes ⁴

Explanation of any answers and additional evidence:

1.As part of the inspection we used a suite of clinical searches and reviewed some patient records. During our review of records, we found the practice had made some improvements to ensure the oversight of record keeping and the quality was measured. However, we found further improvements were required to ensure there was a consistent approach to coding diagnoses and linking medicines to conditions. We discussed this with the practice who were able to tell us that they were working towards this more consistent approach. They recognised the challenge at the moment to have clear oversight of the significant input of many clinical staff from external teams such as the ICS (Integrated Care System) and the PCN (Primary care Network). This quality oversight from the practice leaders was forming part of their protected leadership time within the practice. They had started to hold calls and communication with an external company who they contracted to support their medicines service to discuss and encourage the improvement needed.

2. During our review of records we found an inconsistency in the coding and summarising of medical records. The practice told us they were reviewing the codes and summarising and this was on their action plan.

3&4. At our last inspection March 2022, we reported the practice did not have a system and process in place to ensure test results were managed effectively. At this inspection we found this had been improved and staff were given protected time to manage test results. However, some staff told us that although the system ensured the results were managed in a timely way, the protected time was not always sufficient due to high workload they undertook.

Appropriate and safe use of medicines

The practice systems for the appropriate and safe use of medicines, including medicines optimisation had been improved. However, the systems and process required further review, embedding and sustaining.

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

Indicator	Practice	SICBL average	England 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)	0.79	0.92	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)	11.8%	10.4%	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)	5.65	5.81	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	296.2‰	195.6‰	128.0‰	Variation (negative)
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)	1.59	0.96	0.59	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	19.7‰	12.2‰	6.8‰	Significant Variation (negative)

Explanation of any answers and additional evidence:

At our last inspection March 2022, we noted that staff were aware that the prescribing for hypnotic and psychotropic medicines was high.

At this inspection our findings reflected that they had not improved in this area, although they told us they were aware of the improvements needed. The published and verified data by the NHS Business Service Authority (NHSBSA) highlighted negative variations in data for the prescribing of hypnotics, psychotropics and narrow spectrum AEDs (also known as antiepileptic medicines).

Indicator	Practice	SICBL average	England average	England comparison
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Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial ¹
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	Partial ²
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial ³
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 ⁴
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
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
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>1. The practice demonstrated they had undertaken reviews of non-medical prescribers' consultations to ensure they were prescribing safely and within the required guidelines. Staff we spoke with were aware of these checks but told us they did not get feedback from the GPs undertaking the reviews. They told</p>	

Medicines management	Y/N/Partial
<p>us they had open access to GPs for advice and support should they require it but did not have ample opportunity for proactive and protected learning reviews with the GP leaders. We spoke with the practice who were aware of this but had been challenged to provide the additional time required because of staff shortages. The practice had this on their action plan to improve.</p> <p>2. The practice had improved the system and process to ensure patients who required a full structured medicines review received one. The practice was aware there was a backlog of patients who required a review and had reduced this backlog. They were working with the pharmacy support team to prioritise patients.</p> <p>3. The GPs and pharmacy team were responsible for adding or removing medicines from patients' records. We identified that not all medicines added were linked to conditions. The practice was aware of this and had this on their action plan to ensure all staff were aware and used every opportunity to do this.</p> <p>4. At our last inspection, March 2022, we found the practice systems and processes had failed to fully ensure all patients taking high risk medicines were monitored safely. We found at this inspection this had improved. Our searches indicated that of 34 patients prescribed methotrexate, 2 had not had the required monitoring. We reviewed these records and found that 1 patient was not being monitored in line with the hospital consultant's advice and the other patient had not had all the tests undertaken that are recommended. Our search indicated that of the 14 patients prescribed Azathioprine, 3 had not had the appropriate monitoring. We reviewed these records and found 1 patient had recently joined the practice and the medicine was not on their repeat template, 1 patient did not have a recall date in their records. Records for patient 3 indicated the tests had been done but the results had not been added to the records for ongoing management. We discussed the findings with the practice who were aware that although they had improved their performance, this had been with the support from many external clinicians. The action plan in place showed they were monitoring the work to further improve and sustain those improvements.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	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 8 months	113
Number of events that required action:	113
Explanation of any answers and additional evidence: At our previous inspection the practice did not have an adequate system to routinely learn and make improvements.	

At this inspection, March 2022, the practice told us they had improved the system and process to identify and report events, however minor. We saw the practice had recorded events, however, staff told us they were not confident that events were fully investigated, reported on and learning shared. Some staff we spoke with were unable to share an example of any event they had raised, or from which had shared learning. The practice shared with us their review of events in the past 12 months. They recognised they were not as effective as necessary in identifying the root cause of events or in the extracting and summarising of information for learning points and had prior to our inspection engaged with an external consultant to do this. Examples of trends from reported significant events, included errors resulting from staff shortages and high workload including prescribing errors and missed referrals. From the documentation, we could not be assured that changes had been made and monitored to ensure future issues did not occur. We discussed this with the management team who told us learning outcomes were available on the computer system for staff to look at but accepted they needed to improve the direct feedback and engagement of staff.

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

Event	Specific action taken
Delay in scanning of correspondence resulting in a delayed referral	Patient contacted the surgery as had not received appointment at hospital. Error identified and GP made referral immediately. Practice considered review of referral process. Additional staffing was required to ensure time for staff to manage work safely.
Delay in managing patient with abnormal blood test result.	Task had been sent to reception team and SMS message sent to patient. Patient did not respond for 2 weeks and had failing health. Investigation recognised the task from clinician should have been marked as urgent or the duty doctor should have contacted the patient immediately.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial ¹
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>1. At our last inspection March 2022, we found the practice system and processes to manage safety alerts needed to improve. At this inspection we found the practice had improved the system, and with the external support, all patients who may have been affected by previous alerts had been reviewed. We looked at patients who were prescribed a teratogenic medicine and who were of childbearing age. Our search identified 72 patients. We reviewed the records of 5 of these patients and found 1 patient record did not evidence they had been given the appropriate advice. The practice took immediate action to review this patient.</p>	

Effective

Rating: Requires Improvement

At the last inspection on 1 March 2022, the practice was rated as Requires improvement for providing effective services because:

- The practice's systems to keep clinicians up to date with current evidence-based practice contained gaps.
- There were some examples of cases where patients presenting with symptoms which could indicate serious illness were not followed up in a timely way.
- The practice was unable to demonstrate that staff had the supervision and support to carry out their roles; specifically, across areas of the nursing team and for non-medical prescribers.

At this inspection, the practice is rated as requires Improvement for providing effective services because;

- The practice was able to demonstrate that staff had some supervision and support to carry out their roles however this was not always with the staff member present or as pre planned proactive learning.
- The practice did not undertake documented role specific inductions with new staff.
- Areas of improvement in relation to managing patients with long term conditions had not been completed. The practice was working with an action plan to ensure all patients were reviewed effectively and in a timely manner. Staff levels compromised this recovery work.

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

Effective needs assessment, care and treatment

Although improved, patients' needs were not always assessed, and care and treatment was not always 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.	Partial ¹
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial ²
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial ³

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 prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence:	
<p>1,2,&3. At our previous inspection March 2022, we found patients' care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance.</p> <p>At this inspection, we found that the practice had made improvements and had a detailed action plan to ensure improvements continued to be made and were sustained. We found the practice systems to manage medicines including safety alerts and pathology had improved, however staff we spoke with told us they were challenged by and concerned that their high workload was not sustainable. The practice was aware of the staff shortages and the need for them to ensure staff recruitment was ongoing and retention of staff achieved. The practice had a significant number of external support staff to help drive the improvements.</p>	

Effective care for the practice population

Findings

- The practice actively identified older patients who were living with moderate or severe frailty. Those identified received an assessment of their physical, mental and social needs.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- The practice had a system for vaccinating their eligible patient groups, including patients with an underlying medical condition according to the recommended schedule.
- Patients with a learning disability were offered an annual health check. The practice had a register of 115 patients with a learning disability and in the past 12 months had completed 79% of annual reviews. They told us they worked closely with the community's teams to ensure all patients were reviewed in a place and at a time was best for them.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- 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.
- Evidence viewed during the inspection highlighted that health assessments and checks were not always followed up in a timely manner, including where abnormalities or risk factors were identified.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- There were some examples to demonstrate that patients with long-term conditions were effectively reviewed to check their health and medicines needs were being met. However, in some cases we noted that reviews were unstructured.

- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- There was evidence to demonstrate cases where GPs had followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. However, we identified some gaps in care and asthma management plans for some patients diagnosed with asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. However, we found the practice were still working with their action plan to ensure all patients with chronic kidney disease were reviewed and coded correctly.
- Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Patients with 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	125	135	92.6%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	133	147	90.5%	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)	133	147	90.5%	Met 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)	134	147	91.2%	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)	173	204	84.8%	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

Staff we spoke with described an opportunistic approach to childhood immunisations and we saw that the practice had safe and effective arrangements for following up on any missed immunisation appointments. When necessary, the practice would liaise with other agencies including health visitors and school nurses and consult their safeguarding procedures if required.

Cancer Indicators	Practice	SICBL 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)	62.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.0%	70.2%	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)	58.0%	70.4%	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)	40.0%	53.8%	55.4%	No statistical variation

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

Any additional evidence or comments
The practice was aware of their lower performance in respect of cervical cancer screening. Appointments were available outside work hours and on Saturdays through the practice's Primary Care Network.

Monitoring care and treatment

The practice demonstrated some evidence to show they monitored patient outcomes, care and treatment.

	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

There were some examples of improvement activity in the practice in the past two years. Examples included an audit focusing on non-attenders for cancer screening appointments in an effort to encourage uptake and explore patient engagement.

We noted the practice had, since our last inspection, undertaken a series of searches and audits to improve their management, oversight and safety of prescribing. These quality assurance processes had been recently introduced and required more time to show they were effective, embedded and improvements sustained.

The practice shared with us evidence of checks undertaken through the review of non-medical prescribers' consultations. Staff we spoke with were aware of these checks but told us they did not receive feedback. They told us they had easy access to GP for advice if they needed, but that they did not get the opportunity for proactive and random case review and discussion.

Any additional evidence or comments

At the last inspection, March 2022, the practice had failed to demonstrate they monitored performance and outcomes for patients.

At this inspection the practice shared with us their action plan to ensure all issues identified were improved upon. As part of this action, the practice demonstrated they reviewed and monitored outcomes to develop and embed systems to ensure the improvements were sustained.

Effective staffing

The practice was able to show 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.	Partial ¹
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.	Partial ²
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.	Partial ³

Explanation of any answers and additional evidence:

1. The practice shared with us the generic induction plan used for all staff starting at the practice. They did not have any role specific induction packs. They told us staff undertook a role specific induction, but it was not documented. We spoke with staff who told us this created gaps in their knowledge and understanding and did not ensure all staff received an appropriate and supportive induction.
2. Staff told us they had regular appraisals and could speak with the management team if they needed. However, staff we spoke with told us they did not receive proactive supervision with protected time to identify any training needs they might have. We spoke with the practice who told us they recognised this, but due to the staff shortages and the improvement plan, this had not been addressed as yet. They told us they recognised this was important and was part of their action plan to improve.

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

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

Consent to care and treatment

The practice 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.	Yes

Caring

Rating: Good

Kindness, respect and compassion

At our last inspection we rated the practice as good for caring, at this inspection the practice is still rated as good for providing caring services

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgmental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

Patient feedback	
Source	Feedback
Healthwatch Norfolk	We reviewed the most recent ten reviews which had been received since June 2022. There were 3 5-star reviews regarding kind and caring staff, 3 3-star reviews regarding a delay in treatment and a poor attitude of a receptionist and 4 one-star reviews mentioning unhelpful staff and a lack of appointments. The practice had not responded to any of these comments.
NHS Website	We reviewed all 4 comments which had been received since December 2020. There were 2 five-star reviews mentioning kind and caring staff, 1 2-star review mentioning a poor attitude of a receptionist and 1 1-star review mentioning difficulty in accessing an appointment. The practice had not responded to any of these comments.
Care Home representative	We spoke with a care home representative who was positive about the care that was shown by practice staff towards the patients, relatives and carers.
Compliments	The practice received compliments via email, cards and some verbal feedback. The compliments we saw were positive about the care shown by practice staff.
Feedback through CQC share my care	Comments received from the CQC were mixed in respect of the care shown and given by the practice to patients. Patients commented on the positive and helpfulness of staff but also some commented that the communication was not always caring and supportive.

National GP Patient Survey results

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

Indicator	Practice		SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the	76.7%		86.4%	84.7%	No statistical variation

Indicator	Practice		SICBL average	England average	England comparison
last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)					
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	78.5%		85.8%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	91.2%		94.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	66.7%		75.7%	72.4%	No statistical variation

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

Any additional evidence
The practice submitted evidence that they had collected feedback from patients using the family and friends test. In addition, they had reviewed information from the GP patient survey data and developed an action plan. The practice had also held their first PPG meeting to gather further patient voice and discuss improved communication.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

Source	Feedback
Interviews with patients.	Patients we spoke with were generally positive about being involved in decisions about their care and treatment.
Care home representative	Care home representatives we spoke with were positive about the communication between the GP's, patients, relatives and carers.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England 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 (01/01/2022 to 30/04/2022)	85.4%	92.0%	89.9%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	2% (292 patients were on the practice's carers register).
How the practice supported carers (including young carers).	Carers were offered longer and flexible appointments, as well as vaccinations in line with the national immunisation schedule. Carers were signposted to local support services.
How the practice supported recently bereaved patients.	The practice signposted patients to local support organisations for bereavement care, guidance and support. Bereaved patients were offered a phone call with the GP where appropriate.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Good

At our previous inspection we rated the practice as good for responsive services, at this inspection the practice is still rated as good for providing responsive services.

Responding to and meeting people's needs

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

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

Practice Opening Times

Day	Time
Opening times:	
Monday to Friday	8am – 6pm
Telephone calls received after 6pm were answered by the 111 service but a GP from the practice was available to respond to any urgent calls.	
Appointments available:	
Monday	9am – 12pm and 3pm – 5.45pm
Tuesday	9am – 12pm and 3pm – 5.45pm
Wednesday	9am – 12pm and 3pm – 5.45pm
Thursday	9am – 12pm and 3pm – 5.45pm
Friday	9am – 12pm and 3pm – 5.45pm
Patients could also be seen at the two practice branch sites: The practice's branch at Adelaide Street Health Centre was open between 9am – 5pm. The practice's additional branch at Bates Green Health Centre was open between 9am – 5pm.	

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

- The practice liaised regularly with the community services to discuss and manage the needs of vulnerable patients and patients with complex medical issues.
- The practice could directly refer patients into their wellbeing service and to a mental health nurse practitioner, physiotherapist and social prescriber who were available on site, one day a week.
- The practice offered home visits and urgent appointments for those with enhanced and complex care needs.
- A daily home visiting service was also available for eligible patients, this was facilitated through the practice's Primary Care Network.

- There was a medicines delivery service for housebound patients available through the local pharmacy.
- We were assured that parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Patients could access appointments on evenings and Saturdays at 2 local practices through the Primary Care Network and this included nurse appointments. Patients could also attend the two branch sites at Adelaide Street and Bates Green Health Centre for appointments.
- Patients could access health advice, book a range of health reviews and assessments including asthma reviews and smoking cessation, through an online health review and assessment clinic. This was accessible through the practice website.
- In addition, patients had access to Consulting Room. This enabled patients to raise non-urgent health and wellbeing queries through the practice website, with an aim to get a response from the practice within two hours.
- 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.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to 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 (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Although the evidence we reviewed highlighted a theme pertaining to staff absence which sometimes resulted in non-attendance for GP shifts, there was no evidence from a patient perspective to suggest that patients had issues accessing their care as a result of this. We noted examples from the practice's significant events indicating that where absences had occurred, other members of the clinical team stepped in to offer clinical cover. Patients presenting at the local Emergency Department (ED) could access a GP or an Advance Nurse Practitioner (ANP). This service, known as GP Front Door, was set up in collaboration with North Norfolk Primary Care and South Norfolk HealthCare in December 2019 and available to patients across the Primary Care Network. The main objective of the service was to reduce the footfall through the Emergency Department (ED).</p>	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England 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 (01/01/2022 to 30/04/2022)	59.7%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	54.1%	61.7%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	60.4%	59.8%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	65.0%	77.0%	71.9%	No statistical variation

Source	Feedback
For example, NHS Choices	NHS Choices patient feedback (made within the last 12 months) referred to a lack of availability regarding GPs at the practice.
Patients we spoke with or had feedback from	The feedback from patients was mixed in relation to access. Some patients told us there were delays in getting through on the phone and seeing a GP face to face.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care, although learning was not always shared with staff.

Complaints	
Number of complaints received in the last year.	18
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Partial ¹
<p>Explanation of any answers and additional evidence:</p> <p>We noted in the 2 complaints we reviewed that the practice had responded to the patients with a final letter, however, they had not included the details of the parliamentary ombudsmen or others should the patient not be satisfied with the practice response.</p> <p>Through the exercise of learning and making improvements since our last inspection, the practice recognised they still needed to improve their learning outcomes from complaints. Staff had told us they did not always get invited to give feedback or be involved in the complaint investigation. They also told us they did not get feedback in a way that was helpful. The practice told us staff had access to the learning logs, but this was as part of their improvement plan undertaking addition root cause analysis training.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Poor care and monitoring	Patient received apology and was given details of learning outcomes which included; Review of practice high risk medicine monitoring Recognising signs of toxicity from high risk medicines GP workload and changes to consultations since the COVID-19 pandemic.
Verbal complaint – repeated ECG as not scanned onto patient record	Patient received written apology. Staff learning outcome included making sure staff were aware of the process to scan test results onto patient records and to email the clinician involved.

Well-led

Rating: Requires Improvement

At the previous inspection on 1 March 2022, the practice was rated as Inadequate for providing well-led services because:

- The practice did not demonstrate a clear vision and credible strategy to provide high quality sustainable care.
- There was a lack of clinical oversight in areas which impacted on safe and effective patient care.
- Lines of accountability and leadership were unclear and lacked visibility.
- There was no evidence to support a clear governance framework in the practice and there were gaps in governance and management of risk across some systems and processes.
- There was a lack of evidence to demonstrate active patient, public and staff engagement.
- There was some evidence of low morale at the practice and evidence of a closed culture at times.

At this inspection, the practice was rated as Requires Improvement for providing well-led services because;

- The practice and leaders had been fully engaged with the external support provided by the ICB.
- They were working to a clear action plan and had made improvements. These improvements had been newly established and required further time to be fully implemented, embedded and monitored to ensure improvements would be sustained.
- The clinical oversight had been improved and increased and the leaders had greater awareness of their responsibilities in driving and monitoring the improvements needed. They had developed a new management structure which needed to be embedded to ensure safe and effective services were delivered.
- The governance framework had been strengthened to identify and manage gaps or actions required that had been identified through risk assessments.
- There continued to be evidence of low morale at the practice and evidence of a closed culture at times. However, some staff told us this had started to improve.

Leadership capacity and capability

There was improved leadership however, leaders could not wholly demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Partial ¹
There was a leadership development programme, including a succession plan.	Partial ²
Explanation of any answers and additional evidence: 1. At our last inspection, March 2022, we reported that information, feedback and evidence gathered during our inspection highlighted gaps across systems and processes. There was a lack of effective clinical oversight in some areas and effective safety netting was lacking. In other areas, lines of accountability and leadership were unclear and lacked visibility.	

At this inspection, March 2022, the leaders told us of the improvements they had made after gaining feedback from the inspection findings and through conversations and feedback from staff directly. They had restructured the management team to use a wider skill mix and role sharing. The leaders told us they were aware this was a newly formed management team which needed time to develop and establish clear roles and responsibilities. They were also aware of the staff shortages which still had a negative impact on staff.

Staff told us there had been improvements in respect of visibility of the leaders and improvements had been made. However, staff always told us they found there were further improvements needed as they were not confident the leaders respected their contributions to identifying areas of improvement and suggestions from staff. Staff also reported there were communication failures in gaining feedback in a constructive way when they had reported concerns or issues. Staff told us they were often unaware if action had been taken or why changes were made in the way they were.

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial ¹
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial ²
Progress against delivery of the strategy was monitored.	Partial ³
Explanation of any answers and additional evidence:	
<p>1,2,&3 Conversations with staff demonstrated a clear understanding of the practice's patient demographic and all staff we spoke with expressed that patient care was the top priority in their roles. We also discussed the practice's future plan to bring the 3 practice sites together and there were plans to build a new practice health centre, with a bid to purchase some land underway.</p> <p>At this inspection we found the practice had worked with the local ICB and some staff to develop a clear action plan in line with the vision. However, some staff we spoke with reported they had not been as involved in the discussions and improvements as they thought would be beneficial. Some staff reported they had given some suggestions but did not feel listened to.</p> <p>We spoke with the practice leaders who explained to us they had tried to include the thoughts and suggestions of staff. They told us they were still committed to improving their relationship with staff and were actively recruiting new staff.</p>	

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial ¹
Staff reported that they felt able to raise concerns without fear of retribution.	Partial ²
There was a strong emphasis on the safety and well-being of staff.	Partial ³
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.	Partial ⁴
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection, March 2022, we reported that feedback gathered during our inspection highlighted some supportive team working in individual teams however there was a lack of evidence of whole team working and, in some cases, there was evidence of poor working relationships between different staffing groups.</p> <p>At this inspection staff told us that improvements had been made in some areas, however some staff reported that they did not have confidence that issues they raised were also taken seriously by leaders or dealt with in an unbiased manner. We discussed this with the partners who told us they had engaged with staff to understand their concerns and would continue to do this, they also reported that they had engaged external support to facilitate the improvements needed in staff and management team relationships.</p>	

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

Source	Feedback
Inspection information, feedback and evidence gathered during the inspection	<ul style="list-style-type: none"> Staff reported there had been positive changes in communication with the management team. Some staff reported that they did not always feel that the leaders and management team responded to concerns or issues in an unbiased way. Staff were proud of the improvements made so far and were committed to the journey for further improvement Staff reported they were proud of the team they worked with and the care given to patients.

Governance arrangements

The overall governance arrangements had improved however these were newly implemented and not all effective.

	Y/N/Partial
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There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Partial ¹
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes ²
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. Some staff we spoke with were clear about the roles and responsibilities, but this was not always the reflection of all staff. Several of the new roles and responsibilities had been newly acquired and more time was required for staff to understand their role, the full responsibility and how that impacted on other members of the team. For example, the newly formed management/leadership team had recognised that communication needed to flow better to the leaders and information/decisions needed to be shared back with the staff. 2. The action plan the practice was working to detailed the full recovery of backlogs. It showed that to reduce and clear these backlogs, additional staffing was required. The practice had a recruitment strategy and had been successful in recruiting to many posts but did recognise that acquiring additional clinical staff was essential to addressing all the shortfalls. 	

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

	Y/N/Partial
There were assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial ¹
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>1. At this inspection, the practice demonstrated an improvement in managing risks, however, these needed to be developed further, implemented, and monitored to ensure the improvements made were effective and sustained. For example, not all risks identified in risk assessments such as fire safety or recruitment had been managed in a timely way. However, new assessments or procedures had been undertaken or were in discussion, and the practice told us action plans would be developed from these.</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.	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice demonstrated a commitment to making the improvements needed to support decision making and deliver high quality safe care. The practice was working with external support teams such as the ICB to make these. The practice was aware of the need to ensure the practice would monitor and have the capacity to sustain the systems that would ensure safe decision making.</p>	

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
Staff are supported to work remotely where applicable.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial ¹
The practice had an active Patient Participation Group.	No ²
Staff views were reflected in the planning and delivery of services.	Partial ³
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>1&2. The practice was in the process of developing a PPG which would be instrumental in the practice gaining the view of patients.</p> <p>3. The practice was aware of engaging staff in the planning and delivery of services. Not all staff we spoke with thought the leaders did this in an unbiased way. We discussed this with the leaders who acknowledged it was difficult to engage with all staff, but they were committed to working at this and improving.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice had committed to working with others such as the ICB to develop and work with an action plan to address the issues raised at our last inspection. Protected time for the leadership team had been put in place, giving the leaders time to address and plan and encourage improvement.</p> <p>Although we saw some examples of learning, changes and improvement at the practice, there were various examples where continuous learning and improvement contained gaps. For instance, significant event reports did not always show actions taken or lessons learnt. Evidence of shared learning throughout the practice as a whole was not wholly effective. There was an example of repeated incidents, some of which related to staff workload.</p>	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the 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 SICBL 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 SICBL 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.