

Care Quality Commission

Inspection Evidence Table

Stanley Medical Centre (1-2228914391)

Inspection date: 9 and 16 December 2021

Date of data download: 10 December 2021

Overall rating: Inadequate

We carried out a remote assessment of Stanley Medical Practice in November 2020 following information of concern was raised with the Care Quality Commission. At this time, we issued the provider with two warning notices for Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and Regulation 17 HSCA (RA) Regulations 2014 Good governance. A follow up inspection was carried out in June 2021 during which time improvements had been made. However, we issued a requirement notice in respect of a breach of Regulation 18 (staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We carried out an inspection to Stanley Medical Practice on 9 and 16 December 2021 and have rated the practice inadequate overall and for being safe and well-led. We have rated the practice as requirement improvement for effective, responsive and for providing caring services.

Safe

Rating: Inadequate

The practice was rated as inadequate for providing safe services. This was because:

- Recruitment checks were only partially carried out in accordance with regulations.
- Partners and staff were not trained in safeguarding matters to appropriate levels for their role.
- Health and safety risk assessments, including fire risk assessments were out of date at the time of inspection.
- Systems and processes to monitor significant events were ineffective. There was limited evidence of learning and dissemination of information for the management of significant events.
- Risk assessments for infection prevention and control measures were incomplete and risks to patients and staff were observed.
- Staff did not have the information they needed to deliver safe care and treatment. There was no documented approach to test results. We identified a large backlog of patient correspondence and tasks, resulting in delays to treatments for patients.
- The systems in place for monitoring patients' health in relation to the use of medicines including high risk medicines, such as lithium required improvements.
- The safety alerts were not being acted upon consistently.
- The practice had a remote assessment in November 2020. At this time a Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment warning notice was issued for concerns relating to how the practice managed patient safety. A follow up inspection was carried out in June 2021

during which time improvements had been made. However, at this inspection in December 2021 there was clear evidence to show that improvements made, had not been sustained.

Safety systems and processes

The practice did not have 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.	Partial
Partners and staff were trained to appropriate levels for their role.	N
There was active and appropriate engagement in local safeguarding processes.	Partial
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.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Some staff were not trained to the appropriate level of safeguarding adults and children training as recommended in the Intercollegiate Guidance documents. For example, administrative staff who had contact with patients were only trained to level one. Practice nursing staff were only trained to level two. Named GP's were not trained to level four. Some staff were not clear who the safeguarding lead was and meetings with other healthcare professionals were arranged between clinicians on an as and when basis and not formalized. Staff identified as the site safeguarding lead, were not aware of this during discussions with them. Disclosure and Barring Service (DBS) checks were not undertaken for all locum staff working at the practice. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The provider had employed a new member of staff and was currently reviewing all recruitment records to ensure the correct documentation was kept. Some of the records had been printed off in staff files and other documents were kept electronically. We reviewed three recruitment records for administrative staff which demonstrated appropriate checks had been carried out. Recruitment checks to verify the registration of clinical staff were in place. Systems and processes for safe recruitment of locum staff employed directly by the provider were not in place. The provider used a high number of locum staff to maintain clinical staffing levels. 	

We found that locum staff could work at the practice without any written agreement or contract in place. There was limited and, in some cases, no written information held for GP locums who were working alongside practice staff providing services to patients. In the absence of this information the provider could not be assured the appropriate checks had been undertaken and staff were appropriately trained.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: last completed in June 2015 – date set for new assessment on 11/01/2022	N
There was a fire procedure.	Y
Date of fire risk assessment: Fire risk assessment planned for 11/01/2022 Actions from the previous fire risk assessment were identified and completed.	N
Explanation of any answers and additional evidence: The provider had not completed a health and safety risk assessment of the building since June 2015. A new assessment for the health and safety risk assessment and fire risk assessment was scheduled for 11 January 2022. The provider had employed a buildings manager to start in January to oversee the risk assessments and implement the actions identified.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: November 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> An infection prevention and control (IPC) audit had been undertaken in November 2021. No actions had been identified as part of the audit. However we found shortfalls in the practice in relation to infection prevention and control. Handwashing soap dispensers in two consultation rooms were broken and not dispensing soap. One room had no soap in and only had two hand gel sanitisers. Neither room had paper towels. Both rooms were in use vaccinations and consultations with patients. A detached plug was found in the hand washing sink. Two consultation rooms had fitted furniture that was in a poor state of repair. The plinth of the top of a worksurface was missing which exposed areas that could not be easily cleaned. The handwashing sink in this room was also used to dispose of urine tests, the practice did not have 	

a designated 'sluice' area. The edging of a cupboard door was hanging off in another room, again it could not be easily cleaned.

- A full sharps bin was found in a vaccination room dated November 2020 which was still open.
- The practice only had one spill kit which was not dated and kept in an unlocked cupboard.
- Practice staff had not undertaken further IPC COVID-19 training.

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
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
There were enough staff to provide appointments and prevent staff from working excessive hours	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At the time of inspection, the practice had a number of administration staff and GP vacancies. The practice was being supported by staff from other practices and with agency and locum staff. Staff turnover was high. The provider was aware further staff were needed, however, there had been no formal review of staffing levels, mix and ratios. The provider told us they were trying to recruit; however, it was proving difficult to do so. • Staff interviews and a review of staff records showed that a thorough induction process had taken place for those permanently employed. 	

Information to deliver safe care and treatment

Staff did not have 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.	Partial
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.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	N

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Overall, the consultation records we viewed were well written, however, they lacked confirmation that a chaperone was offered to patients. The process for referring patients to other services required review. Some referrals were made to other services and limited information was provided which resulted in the referral being returned to the practice and a delay in the patient receiving care. Clinicians told us they tended to make their own referrals to other services and would follow them up as the practice system did not work. During our first visit on 9 December 2021 there was a back log of patient correspondence, tasks and test results identified on the practice patient record systems. This had been reduced on our second visit but delays still occurred and not all the outstanding correspondence had been actioned. The provider did not have oversight of the management of patient related correspondence and test results. Staff told us they dealt with it as and when they had time. Administrative staff did not have access to the shared computer drive to access policies and procedures and would flag what they thought was urgent to clinicians rather following a specific process. We saw evidence that this resulted in delays in care and treatment for patients. For example, another care provider recommended an antibiotic for a patient. The request was filed and not reviewed by a clinician. It was actioned at the patients next contact with the practice two weeks later. The practice did not have appropriate clinical oversight of blood test results. Our searches identified an abnormal blood test result for patient in June 2021 with significant risks, and there was no evidence that this patient had been followed up by the practice. We shared our findings with the provider at the time of inspection and assurance was given following our visit that these patients were reviewed immediately. 	

Appropriate and safe use of medicines

The practice did not always have 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) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.82	0.82	0.71	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). (01/10/2020 to 30/09/2021) (NHSBSA)	7.7%	9.1%	9.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r	5.95	5.46	5.32	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2021 to 30/09/2021) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	383.3‰	220.1‰	126.1‰	Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	1.05	0.94	0.63	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	11.6‰	11.4‰	6.7‰	Tending towards variation (negative)

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.	N
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
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.	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
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.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y

Medicines management	Y/N/Partial
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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches are visible to the practice.</p> <ul style="list-style-type: none"> • The provider had implemented monthly monitoring of high-risk medicines, this was undertaken by a central team of pharmacists and shared with other related practices at monthly clinical meetings. • Patients prescribed Lithium were not effectively monitored. Six patients were prescribed this medicine and two patients were not being monitored safely. For example, one patient had abnormal blood results in August 2021, and this had not been followed up by the practice by 16 December 2021. • We found that annual medication reviews for patients diagnosed with asthma had not occurred. • The practice monitored the prescribing of controlled drugs and was aware of and monitoring the high prescribing of Pregabalin or Gabapentin. • Emergency medicines and equipment were checked monthly rather than weekly as recommended by the UK Resuscitation Council. Additional medicines were kept that were not listed on the check list and staff manually documented them onto the list each time it was checked. On the day of inspection two vials of intravenous antibiotic were missing from the emergency medicines trolley. Staff could not account for their use. The last check was completed on 13 December 2021 where they were marked as present. We asked the provider to report this as an incident and notify us of the findings. • The provider did not have oversight of non-medical prescribers and locum staff. Reviews of consultations had not taken place for six months. Clinical supervision arrangements were not in place, other than informal support from other clinicians on a day to day basis. 	

Track record on safety and lessons learned and improvements made

The practice did not have a robust system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	6
Number of events that required action:	Unclear
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Systems and processes to monitor significant event occurrences were ineffective. • Staff did not always report incidents using the practice incident form and tended to share their concerns verbally with the provider. • Records relating to significant events lacked clear evidence of the action taken, a timescale for completion or a date for review. • We looked at six significant event reports and found there was insufficient evidence that incidents were discussed with staff involved, or that any learning had been identified. • Staff discussed with us a number of incidents that should have been reported as a significant event. We identified a number of patient complaints that should have been reported and investigated as a significant event. 	

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

Event	Specific action taken
Medicine error incident when patient was discharged from hospital.	No details were provided of any investigation. Records show that the error was identified by clinician when reviewing patient discharge handwritten information and medication was updated to ensure correct dose. The learning identified was that staff should take time when reviewing handwritten requests to changes medicines.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Not all Medicines and Healthcare products Regulatory Agency (MHRA) alerts were being acted upon. We looked at the MHRA alert for the prescribing of the medicines ACEi or ARB and 	

Spironolactone, which identified that a concomitant use increases risk of severe hyperkalemia. Our clinical searches showed that eight patients had these medicines prescribed together. Five patients had not had a review and there was no evidence in these records that patients had been informed of the associated patient safety risks.

- The practice did not keep a record of all MHRA alerts or document action taken as a result of the alert.
- Staff we spoke with were unclear about the systems in place for responding to safety alerts.

Effective

Rating: Requires Improvement

The practice was rated as requires improvement for providing effective services. This was because:

- Patients' care and treatment was not regularly reviewed and updated.
- The practice did not have an effective system for following up on blood test results and tasks that required immediate action. This led to increased risks that patients presenting with symptoms which could indicate serious illness not being followed up in a timely and appropriate way.
- Children's immunisation rates were below the 90% minimum national target.
- The uptake of cervical screening for women was below the 70% uptake for national targets.
- There was limited monitoring of the outcomes of care and treatment.
- Information to show that staff had the skills, knowledge and experience to deliver effective care, support and treatment was not in place for all staff working at the practice.
- Regular appraisals, one to ones and clinical supervision had not taken place for staff.
- Do not attempt cardio pulmonary resuscitation (DNACPR) orders were not adequately recorded.

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 were usually delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. However, improvements were needed.

	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.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
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

Explanation of any answers and additional evidence:

- Patients continued to have access to mental health services at this practice. A dedicated mental health clinician and support was available most days. The clinician was able to prioritise and treat patients, able to signpost and refer onto secondary care and support as needed.
- The practice did not have an effective system for following up on blood test results and tasks that required immediate action. This led to increased risks that patients presenting with symptoms which could indicate serious illness may not be followed up in a timely and appropriate way.
- Patients treatment was not always reviewed and updated in a timely manner as the practice did not have appropriate clinical oversight of test results.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. The practice had a list of vulnerable patients over 75 years. Health checks, including frailty assessments, were offered to patients over 75 years of age.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- All patients with a learning disability were offered an annual health check, the practice worked closely with the mental health team to support patients. A register of patients living in vulnerable circumstances was reviewed by clinicians.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a mental health nurse who assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. There was a system for following up patients who failed to attend for administration of long-term medication. Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- The provider had a central recall system to book appointments for patients for an annual review of their long-term condition. The practice monitored long term conditions by setting up a search on the practice computer system, to identify patients with long-term conditions who were due an annual review. These searches were run on a monthly basis to find patients who were due the following month.
- However, we identified that some patients who needed an annual review did not have this completed. For example, those diagnosed with Asthma.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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)	41	51	80.4%	Below 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)	31	35	88.6%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	31	35	88.6%	Below 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)	31	35	88.6%	Below 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)	35	49	71.4%	Below 80% uptake

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

Any additional evidence or comments

The practice did not meet the WHO based national target of 95% (the recommended standard for achieving herd immunity) for childhood immunisation uptake indicators. The smaller number of patients registered at this practice under the age of 5 affected the overall percentage.

The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care. For missed immunisation appointments we were told the nurse liaised with health visitors when necessary.

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)	57.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	59.7%	63.8%	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)	50.8%	55.0%	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)	44.0%	49.1%	54.2%	No statistical variation

Any additional evidence or comments

- The percentage of women eligible for cervical cancer screening who were screened adequately within a specified period was stated at 57.5%, which is below target. The overall trend demonstrated some improvement in uptake during 2021.
- Staff were aware of this and actively promoted cervical screening uptake within the practice. For example, patient literature available in waiting the room and information on the practice website. Limited practice nurse availability affected the number of cervical cancer screening appointments the provider could offer.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

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

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

The provider had a set number of clinical searches on the patient record system to identify where care and treatment could be improved. Pharmacists had undertaken some audits to ensure appropriate medicines were prescribed.

The provider did not have a planned schedule of clinical audit or quality improvement and described it as being reactive to advances in care and treatment.

Effective staffing

The practice was not always 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.	Partial
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.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- The provider did not have oversight of non-medical prescribers. During our review of patient records we identified prescribing practice which was not in line with national guidance for some medical conditions. The provider assured us that these patients were reviewed following the inspection.
- We reviewed the records of staff training considered to be mandatory by the provider which included safeguarding adults and children, infection prevention and control, resuscitation, health and safety, fire safety and data security. We found some nurses and long-term locum GPs had not completed level 3 safeguarding for adults and children, as recommended by Intercollegiate Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff and Adult Safeguarding: Roles and Competencies for Healthcare Staff practice guidance. Staff had not completed infection control training.
- There were no records held to confirm that locum GPs had completed all the required training so the provider could not be assured that these staff had the skills, knowledge and experience to deliver effective care, support and treatment.
- There was no documented evidence that clinical supervision took place.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Practice systems were in place to ensure information was safely shared within the practice and with external providers.Systems were in place to use special notes so that patient information could be shared with out of hours services to ensure consistency of care for patients. For example, patients on an end of care pathway.	

Helping patients to live healthier lives

Staff were 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:	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • During the inspection we identified four patients with a current 'Do not attempt cardio pulmonary resuscitation' (DNACPR) decision in place. We asked the provider for sight of these DNACPR records, and for the relevant information held in clinical records. The practice did not hold a paper or electronic copy for the first patient we identified. The clinical records indicated it had been put in place in May 2021. Staff told us it was completed by community nurses so would be in the patient's home. • For the other patients there were a mix of a paper and electronic copies of the DNACPR order. In some cases, there was no evidence of a clearly documented reason for the. • Some recorded family members were involved in the decisions. The patient's mental capacity and ability to make their own decisions had not been captured in the records. Some parts of the forms were incomplete. • One decision had not been reviewed within the previous 12 months. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff we spoke with showed they respected the personal, cultural, social and religious needs of patients. They demonstrated a non-judgmental approach to patients and told us that if patients were to become upset, they would be offered some private time in one of the rooms at the practice. Staff told us that during the pandemic they had undertaken an initiative by providing patients with food hampers for those patients who most struggled at this time. 	

Patient feedback	
Source	Feedback
Patients	Staff are caring and try to do their best for patients.

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)	68.9%	90.8%	89.4%	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)	70.3%	90.0%	88.4%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and	81.9%	95.4%	95.6%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)				
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)	64.8%	83.8%	83.0%	Tending towards variation (negative)

Any additional evidence or comments
<p>The practice had not undertaken a recent patient survey and the provider explained this was due to the pressures the practice experienced across the COVID-19 pandemic. The practice continued to monitor patients views via the Friends and Family patient feedback.</p> <p>The provider was aware of the lower satisfaction with the NHS GP patient survey results and suggested this was due to the high turnover of staff at the practice.</p> <p>The provider routinely monitors the NHS Choices website to monitor patient reviews.</p>

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

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Observation of staff interactions with patients on the day of inspection demonstrated they were understanding of patients' needs and they were trying to help them access local support and advisory services. 	

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	78.9%	93.2%	92.9%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
their care and treatment (01/01/2021 to 31/03/2021)				

	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
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	Awaiting information from the provider
How the practice supported carers (including young carers).	
How the practice supported recently bereaved patients.	

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The reception area had a glass screen to try and maintain private and confidential conversations amongst staff. All staff we spoke with were aware of the importance of ensuring confidentiality for patients during conversations. 	

Responsive Improvement

Rating:

Requires

The practice was rated as requires improvement for providing responsive services. This was because:

- Patients were not able to make appointments in a way which met their needs and telephone access to the practice was poor.
- The complaints policy and procedure were not followed, verbal complaints were not recorded. Complaints were not responded to in a timely way and not all aspects appropriately investigated.
- There was insufficient evidence that complaints were used to drive continuous improvement.

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"> • Minutes of practice meetings showed the team had previously discussed the needs of the local population and how best to meet them. • All areas of the practice were accessible to those with a disability. • Staff informed us that translation services were available for those patients needing this. Posters were seen in the reception area. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm

Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

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

- Home visits and urgent appointments were available for those with enhanced needs and complex medical issues.
- Patients did not have a named GP who supported them in whatever setting they lived. Instead, the registered provider was identified to be the named GP for all patients across each of his practices.
- Care and treatment for people with long-term conditions and those approaching the end of life was coordinated with other services.
- Most patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. However, annual reviews for patients with asthma required improvements.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers 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.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice employed a mental health practitioner to support patients with mental health needs.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.

Access to the service

People were not 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
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Partial
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had information for patients relating to the COVID-19 pandemic on their website and via telephone messages. • The practice offered telephone, video and face to face appointments. Staff spoken with confirmed arrangements were in place to support patients who were not able to use online communications. • Patients requesting an appointment or consultation had their details taken by a receptionist and added to the triage list. The clinicians reviewed the patients on the triage list and either offered a telephone, video consultation, home visit or a face to face appointment. Receptionists booked appointments for patients who needed to see a practice nurse, a mental health practitioner or receive childhood immunisations. • Feedback from patients about access to treatment was poor. Patients stated they were unable to get an appointment in ways that would meet their needs, including telephone and face to face appointments. • Feedback from patients about telephone access to the practice was poor. There were only two telephone lines coming into the practice and these did not allow for a messaging system. the provider explained that they had raised this with NHS Liverpool Clinical Commissioning Group and were on the waiting list for a new telephone system to be implemented. They had tried another one which was not suitable. 	

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)	53.2%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	54.8%	70.7%	70.6%	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 (01/01/2021 to 31/03/2021)	54.7%	68.4%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	74.3%	84.0%	81.7%	No statistical variation

Source	Feedback
NHS Choices	Members of the public have written on the NHS Choices website concerns about trying to get through to the practice on the telephone and accessing services via the practice on-line portal.
Patient feedback to CQC	Prior to inspection complaints were raised with CQC about telephone access to the practice, dissatisfaction with the triage system and not being able to get an appointment with a GP.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	9
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	Unclear
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y

There was evidence that complaints were used to drive continuous improvement.	N
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Explanation of any answers and additional evidence:

- The practice complaints policy included the capturing verbal complaints. No records were kept for verbal complaints made across 2021 and staff interviewed confirmed they were not routinely reporting verbal complaints. On the day of inspection, we overheard grumbles and complaints from patients that were not recorded. Staff tended to solve the problem for the patient at the point of contact.
- Nine patient complaints were made from May 2021 to 7 December 2021. Investigations for six responses were incomplete and the complainant had not received any further communication from the practice.
- We looked at four complaints in detail and found an acknowledgement letter had not been sent within three working days, in line with the practice policy. Investigations undertaken were not recorded and there was no evidence that learning had taken place and shared with staff when these complaints were made.
- There was no evidence complaints were risk assessed. One complaint resulting in a hospital admission had not been reported or investigated as an incident.

Example(s) of learning from complaints.

Complaint	Specific action taken
From the complaints were reviewed no learning was identified.	

Well-led

Rating: Inadequate

The practice was rated as inadequate for providing well-led services. This was because:

- We identified arrangements were not in place for identifying, recording and managing risks, issues and mitigating actions.
- Staff were unclear about reporting processes and there was insufficient evidence that appropriate actions and learning took place.
- The provider did not have a systematic programme of clinical audits which should be used to monitor quality.
- Structures, processes and systems for accountability were not clearly set out or understood by staff. There was a lack of management and leadership oversight and monitoring of these systems to ensure their effectiveness.
- Patient views were not acted on to improve services and culture.

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels, however leaders were not always on site for clinical leadership and support

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: The provider has other separate provider registrations and locations registered with the Care Quality Commission including nine GP practices, and they are a partner at three others. A senior management structure, led by this provider, operates across 10 GP practices. This included managers for clinical oversight, human resources, finance, governance and communications. Site managers work at this practice along with others. <ul style="list-style-type: none">• The provider did not work from Stanley Medical Centre on a day to day basis and there were no formal arrangements in place to maintain day-to-day management of the regulated activities in his absence.• Staff had told us that if needed the provider was contactable remotely. A small number of staff raised concerns with us about the lack of support when concerns were raised about insufficient clinical staffing levels.• Long term locum staff who worked at the practice focused on providing care and treatment to patients and they did not contribute to the management and leadership of the practice.	

Vision and strategy

The practice had a vision and strategy to provide high quality sustainable care. However, this was not clear for staff.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The provider could articulate their vision and values for providing high quality, accessible care and treatment through a triage model approach using a multi-disciplinary team of skilled clinicians. At the time of inspection there were new members of staff who were not aware of this. There was no evidence this had been developed with patients and external partners or that progress against delivery was monitored. The provider told us that staff recruitment and retention were the main challenges to delivering high quality sustainable care. A newsletter for staff included the vision and values held by the provider. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
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"> We had mixed reviews from staff about working at the practice. Some staff told us they were encouraged to raise concerns and issues without their fear of retribution. Others told us they reported incidents and concerns that were not acted upon. We found incidents were reported verbally and did not follow practice processes. As a result, there was little evidence of action being taken to address concerns. Staff reported some incidents to us that involved the safety and well-being of staff. The provider had not risk assessed these situations and it was not clear what action had been taken to promote the safety and well-being of staff. 	

- The incident reporting form did not capture any communication with patients under the requirements of duty of candour.
- The provider told us they acted on feedback we provided to review some patient consultations. In their response, the provider did not detail whether they had apologised to the patient and provided an explanation of why they had been contacted and a follow up consultation offered.

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

Source	Feedback
Staff interviews	We had mixed reviews from staff about working at the practice. Some of the new recruits were enthusiastic about working there. They were undergoing induction and they felt well supported. Others expressed the view that they that they were not always listened to.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw a number of governance systems and policies that required improvements. For example, the recruitment policy, significant event reporting, complaints management systems and infection prevention and control measures. • Infection control audits were completed however, there was no evidence that an action had been developed to ensure issues identified were addressed and monitored. • There was no effective oversight of the safety alert processes to gain assurance that all relevant staff were notified and subsequent taken. • The practice did not have an effective system for following up on blood test results and tasks that required immediate action. We identified a large backlog of patient correspondence and tasks, resulting in delays to treatments for patients and this had not been monitored effectively by the practice. Staff told us they dealt with it as and when they had the time. • Staff were not always clear about their roles and responsibilities and followed custom and practice rather than established processes. For example, administrative staff did not have access to the shared drive to access policies and procedures when dealing with patient correspondence. They tended to flag what they thought was urgent to clinicians rather following a specific process. • There was limited monitoring of the outcomes of care and treatment. The provider did not have a systematic programme of clinical audits which can be used to monitor quality and improve outcomes for patients. • Information to show that staff had the skills, knowledge and experience to deliver effective care, support and treatment was not in place for all staff working at the practice. 	

- The provider's supervision and support arrangements for staff required improvements.
- The practice had a high usage of both ANP and GPs clinical locums and there was a lack of oversight of their work and performance. We found issues with some consultations we asked the provider to review and contact the patient and report as an incident.
- The provider did not have systems in place to ensure nurses working in advanced roles could demonstrate the necessary training and competence. For example, reception staff were not clear which advance nurse practitioners were competent and trained to see and treat children under two years old.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There were gaps in systems to assess, monitor and manage risks to patient safety. For example, staff were not reporting significant events effectively and we found a number of safety incidents that should have been reported. One such incident involved emergency medicines found to be missing from the emergency trolley. Staff told us of previous situations where emergency equipment was missing from the trolley and unaccounted for. • Staff said the workload was high due to staff shortages for both clinical and non-clinical roles. The provider was aware further staff were needed. There had been no formal review of staffing levels, mix and ratios. The provider told us they were trying to recruit; however, it was proving difficult to do so. • Risk assessments were missing, overdue or had not been completed fully to identify risks and mitigate them. For example, the health and safety risk assessment had not been reviewed since 2015. • Performance for other aspects of the practice was not appropriately monitored. This included performance of staff members when specific issues had been identified and should have been acted upon. • The practice had a business continuity plan in place. Staff had not had formal training in preparation for major incidents, mostly because they were new to the practice. 	

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.	N
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice set up measures to safely separate different patient cohorts. This included continuing to utilise the practice triage system using eConsult with video link and telephone consultations for patients. Home visits and face to face appointments were managed to ensure staff and patient safety and this was closely managed across the Covid-19 pandemic. The practice reviewed the arrangements for providing access to urgent and essential routine GP services. Infection prevention and control protocols, policies and procedures had not been updated in light of the COVID-19 pandemic. Additional training had not been completed by all staff which included the use of personal protective equipment (PPE) to protect staff and patients attending the practice. On our first day of inspection we observed that staff were not wearing masks, or they wore them inappropriately. 	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	N
Explanation of any answers and additional evidence:	

- There was limited evidence shown to demonstrate the practice used data and information to monitor and improve performance.
- The provider had responsibility for making statutory notifications to CQC. The provider did not routinely notify CQC of all high risks, to establish whether they met the threshold for a notification and what that entailed.
- We asked the provider to review a patient's contact with the practice in November 2021, prior to this inspection. The provider has not yet provided the Care Quality Commission with an outcome of their investigation.

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
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

The practice did not always involve 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.	N
The practice had an active Patient Participation Group.	N
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:	

- There was limited evidence that patient views were acted on to improve services. We were told that the practice intended to collect patients views via the Friends and Family feedback. There was little learning and action demonstrated following complaints to the practice.
- The practice did not have a Patient Participation Group and there had been no recent patient survey completed.
- We were told that plans were in place where service developments would be discussed, and a meeting had taken place with all staff in November 2021. Not all staff who worked at the practice attended this meeting.
- The practice was part of a local Primary Care Network reviewing the needs of the local population.

Feedback from Patient Participation Group.

Feedback

At the time of inspection, the practice did not have a Patient Participation Group.

Continuous improvement and innovation

There was limited 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.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a new clinical lead who had recently taken on a management role to develop and support the practice. At the time of inspection, it was too early to assess the effectiveness of this new role, but we were told that continuous learning and making improvements for staff would be a priority. • There was poor evidence that learning had been effectively used prior to inspection to make practice and service improvements. 	

Examples of continuous learning and improvement

We were shown minutes of a meeting held in November 2021. This was the first meeting for the new team and discussions took place about areas that needed to improve and any issues across the practice that needed to be addressed. At a previous meeting held in May 2021 the minutes show that actions identified at previous meetings were on an action tracker and were discussed again to continue to improve. These minutes show discussions about a reported significant event and the learning that could be made for this. However, since May 2021 there was no further evidence to show that meetings included discussions about significant events and patient complaints.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.
-
- $\%$ = per thousand.