

Care Quality Commission

Inspection Evidence Table

Coniston Medical Practice (1-583597179)

Inspection date: 11 October 2021

Date of data download: 13 October 2021

Overall rating: Good

Please note: Any Quality and Outcomes Framework (QOF) data relates to 2020/2021.

Coniston Medical Practice was rated Requires Improvement at their last inspection carried out in October 2019. During this inspection, we identified areas needed to be addressed have improved and we rated the practice as Good for providing safe, effective and well-led services.

Safe

Rating: Good

At the last inspection in October 2019 we rated this key question as Requires Improvement. This was because there was a lack of clear system and procedures to ensure staff that required a DBS had this undertaken and the registration of clinical staff had been recorded and regularly monitored. Health and Safety processes had not been fully acted on. Patient Group Directions principles had not been adapted and there was no effective oversight of safety alerts. At this inspection, we rated this key question as Good, as the improvements have been made in regards to all of the above concerns.

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
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes

Safeguarding	Y/N/Partial
Explanation of any answers and additional evidence: At the last inspection in October 2019, we found there were no clear systems in place to ensure staff that required a DBS check had this undertaken. At this inspection, we saw evidence of DBS checks being completed and additional declarations from employees had been put in place in case the updated DBS was awaited or not confirmed before their starting date. The declaration signed by each employee stated there had been no changes in their DBS status since it was last obtained and presented to the practice.	

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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 1 July 2021	Partial
There was a fire procedure.	Yes
Date of fire risk assessment: 24 August 2021 Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The practice has a Health and Safety policy in place along with regular Health and Safety meetings. These were minuted and actions identified at these meetings were recorded and marked as completed. This meant the practice had a system in place to monitor health and safety risks and we were assured they had an oversight, however, it was not a risk assessment.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 14 September 2021	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

Risks to patients

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

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

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.71	0.60	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	9.9%	10.5%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	4.51	4.64	5.38	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	111.2‰	94.0‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.94	0.58	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	4.9‰	5.1‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	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).	Partial

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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.	Not asked
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 PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had Patient Group Directions in place, which meant all clinical staff administering medication were authorised to do so. However, the practice did not follow the guidance of scoring through the unused rows in the list of practitioners, which posed a potential risk of the practice adding authorisation post managerial sign-off. We reviewed PGDs and were assured that no further staff names had been added post authorisation.</p> <p>Not all of the information regarding patient's medicines had a clear audit trail, for example:</p> <ul style="list-style-type: none"> • Out of 39 patients prescribed Spironolactone, a medicine used to treat fluid build-up due to heart failure, liver scarring or kidney disease, 11 had not had the required monitoring done. However, there was evidence of the practice sending text reminders to patients for outstanding tests or offering appointments. • Some of the patients over 65 prescribed Citalopram 40 mg (an anti-depressant), had not had required monitoring (seven). For example, one patient, who has been on this medication since 	

Medicines management	Y/N/Partial
2012 and had other underlying long-term conditions, which were reviewed regularly, but no mention of Citalopram or mental health in those reviews.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong and have a 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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	15
Number of events that required action:	0

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

Event	Specific action taken
Delay in diagnosis of diabetes. Lack of follow up from a blood test in July 2020.	The patient was seen by a clinician in May 2021, educated and provided with a full new diagnosis. Significant event raised, discussed with all health care professionals at a meeting to avoid events like this happening in the future.
No EMIS alert when a new medication started after hospital admission. The pharmacist found a new prescription for six months during red alert searches.	The issue was recognised during the red drug audit. The consultant who prescribed the drug was contacted. It was explained, that there was an error and a correct course of action was agreed upon. A significant event was raised. Awareness of unfamiliar medication on discharge was discussed at the team meeting.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
We saw examples of actions taken on recent alerts for example, regarding sodium valproate. However, the practice did not have system in place to enable management oversight to ensure all safety alerts were acted on.	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

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

Effective care for the practice population

Findings
<ul style="list-style-type: none">• Health checks, including frailty assessments, were offered to patients over 75 years of age. Face-to-face appointments were offered to the elderly population upon request.• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.• The practice was working with multidisciplinary teams, i.e. learning disability team, palliative care team to support complex patients.• The practice used RESPECT forms to document patients' wishes where appropriate. RESPECT forms record patients' preferences and details of care for emergency treatment. Regular care home ward rounds were completed. During the pandemic, these ward rounds occurred daily.

- End of life care was delivered in a coordinated way that took into account the needs of those individuals whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedules.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice worked with health visitors specialised in working with the travellers' community to encourage vaccination uptake.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- The practice took part in the Recovery and Wellbeing Service pilot, which focused on targeting and supporting patients experiencing mental health issues.
- Patients with poor mental health, including those living with dementia, were referred to appropriate services.
- The practice had dermatoscope on the premises and screening dermatology referrals in place to improve access and treatment for patients.

Management of people with long term conditions

Findings

- All patients with chronic diseases had their regular reviews and care plans in place.
- Reviews of all long-term conditions included taking blood and reviewing medication, allowing all checks to be done in one appointment.
- The practice followed best practice guidance and had appropriate care plans in place for people with a diagnosis of diabetes, asthma and hypertension.
- Out of 39 patients prescribed Spironolactone 11 had not had required monitoring done. However, there was evidence of the practice sending text reminders to patients for outstanding tests or offering appointments.
- Seven of the patients over 65 prescribed Citalopram 40 mg had not had required monitoring. This included one patient, who has been on this medication since 2012 and had other underlying long-term conditions, which were reviewed regularly. There was no reference to Citalopram or their mental health made in those reviews.
- The practice identified patients and changed medication due to MHRA (Medicines and Healthcare products Regulatory Agency) alerts, however, we identified nine of the patients prescribed Simvastatin or Amlodipine had not had required monitoring.
- Staff responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in a hospital or throughout the 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.

- All patients with a diagnosis of diabetes and pre-diabetes were managed appropriately.

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)	122	135	90.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	125	133	94.0%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	124	133	93.2%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	125	133	94.0%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	109	113	96.5%	Met 95% WHO based target

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 met all targets for child immunisation.

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)	70.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	73.3%	70.3%	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)	58.9%	63.4%	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)	55.7%	54.8%	54.2%	No statistical variation

Any additional evidence or comments

Practices' cervical cancer screening uptake was 70.6%, which did not meet the national target minimum of 80%, however, we were presented with the evidence of the practice doing recalls and inviting eligible patients for the test. Patients with previously abnormal results were given priority. The nurses offered additional catch-up clinics. We saw the evidence of practice encouraging eligible patients to take the test.

Monitoring care and treatment

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

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

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

Any additional evidence or comments

The practice supported two care homes in the local community and weekly ward rounds were taking place in both services. Throughout the pandemic when the care homes were under pressure the practice was conducting a ward round daily to best support the patients living in those services.

Despite losing five out of eight salaried GP since the beginning of 2021 the practice managed to work effectively and provide safe care and treatment to patients. The practice had recognised the challenges and proactively sought help. The practice joined the Clinical Commissioning Group's (CCG) Resilience Programme. The practice worked with the CCG to develop strategies and solutions to problems they were facing.

Effective staffing

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

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

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

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

Caring

Rating: Good

Coniston medical Practice was rated Good for the provision of caring services at our last inspection in October 2019. In accordance with Care Quality Commission's methodology, the rating from our previous inspection for this key question has been carried through to contribute to overall rating for the practice.

Responsive

Rating: Good

Coniston medical Practice was rated Good for the provision of responsive services at our last inspection in October 2019. In accordance with Care Quality Commission's methodology, the rating from our previous inspection for this key question has been carried through to contribute to overall rating for the practice.

Well-led

Rating: Good

At the last inspection in October 2019, this key question was rated Requires Improvement. This was due to the governance arrangements not ensuring that effective systems, processes and assurances were in place and regularly reviewed. This meant risks were not managed and mitigated adequately. At this inspection, we rated this key question as Good, as improvements have been made.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The practice recognised the impact of the pandemic on the service and was transparent about the challenges that they were facing since January 2021. They described three main pressures on the system: a covid outbreak in the community, the mass vaccination programme and staff shortages. The practice was proactive in seeking help from the Clinical Commissioning Group (CCG), Local Medical Council (LMC) and Primary Care Network (PCN) facilitating engagement early to mitigate the potential impact that could have occurred through non-engagement. At the same time, the practice had increased support for remaining staff through the use of the Telegram application, a secure online messaging application for better communication and offering health and well-being meetings for all staff. The practice identified that with the current issues, sustainability of their practice was challenged and as such had secured partnership with another larger CQC registered provider in the community to gain additional support and resilience to provide patients with safe care and treatment. The practice entered into this relationship with the provider on 1 October 2021. We were unable to see any improvements as a result of this merger due to the short amount of time since it has taken place, however, the practice was motivated to improve the service.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: The practice had an honest, open and caring culture. Staff told us about a memory service that took place in the summer, considering all patients' religious beliefs. A service was held in memory of all the patients who were affected by the pandemic and those who have lost their lives due to it. With the help of Patchway Council, the practice commissioned a memory bench for all those that lost their lives throughout the Covid-19 pandemic.	

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

Source	Feedback
CQC staff questionnaire	Friendly staff, all focusing on doing the best for patients. Difficult due to staff shortages, but good team work.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	
<p>At the previous inspection, we identified issues with policies and procedures around monitoring risk, which resulted in the breach of Regulation 17 HSCA (RA) Regulations 2014 Good governance. At this inspection we saw the below improvements:</p> <ul style="list-style-type: none"> • Since our last inspection, the practice had recruited a business manager, who has been in place since June 2020. • We saw the evidence of monthly, bi-monthly and quarterly risk assessments audits. This meant there were systems to effectively monitor, identify and manage risks. 	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

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
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Feedback from Patient Participation Group.

Feedback
Limited contact with patients due to the pandemic, however on occasions when PPG representatives attended the practice there were no major concerns or issues raised, only comments regarding accessing the service due to restrictions being in place.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

Examples of continuous learning and improvement

- Patients with pre-diabetes were offered diabetes prevention courses. They received a letter with details of the Healthier You Diabetes Prevention Course and were recalled for an annual check.
- The practice acquired a dermatoscope and one of the GP's has undertaken the training. This was to reduce the number of patients being referred for benign skin lesions.

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.
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- %_o = per thousand.