

# Care Quality Commission

## Inspection Evidence Table

### Jubilee Park Medical Partnership (1-570676592)

Inspection date: 7 December 2022 13 December 2022

Date of data download: 06 December 2022

## Overall rating: Inspected not rated

The practice was rated as Inadequate at the Care Quality Commission (CQC) inspection in October 2022. Following the inspection, the practice was served with four warning notices in relation to Regulation 12 (safe care and treatment) Regulation 17 (Good Governance) Regulation 16 (complaints) Regulation 15 (premises and equipment)

At our inspection in October 2022 we found that:

- The practice's systems and processes did not always keep people safe.
- Risk to patients' staff and visitors were not always assessed, monitored or managed effectively.
- The arrangements for managing medicines did not always keep people safe.
- There were not always effective processes and systems in place to support good governance.
- The practice's processes for managing risks, issues and performance were not effective.

The follow up inspection was undertaken in December 2022 to review compliance with the warning notices served at our last inspection in October 2022 and which had to be met by 30 November 2022.

The inspection was not rated and therefore the ratings remained unchanged. The practice continues to be in special measures and will receive a further inspection to review progress in all areas within six months of the original inspection report publication date, and that inspection will be rated.

## Safe

## Rating: Inspected not rated

At the inspection in October 2022, we found areas of concern that impacted on patient safety. This key question was rated as Inadequate and this was due to:

- The practice did not have systems and processes in place to keep people safe.
- There was poor oversight and maintenance of the premises including fire, legionella and infection control.
- Not all staff had completed safeguarding training or were trained to the required level.
- Appropriate standards of cleanliness and hygiene were not met.
- There were gaps in systems to assess, monitor and manage risks to patient safety such as staffing levels and responding to a medical emergency.

- Staff did not have the information they needed to deliver safe care and treatment due to a backlog of correspondence.
- The practice did not have systems in place for the appropriate and safe use of medicines, including medicines optimisation.
- There were concerns relating to the monitoring of patients taking high risk medication.
- There was poor management of care information and task management issues.
- The practice could not demonstrate the prescribing competence of non-medical prescribers.
- The practice could not demonstrate an effective system to ensure that learning was implemented when things went wrong.

This inspection in December 2022 was not rated and therefore the rating of inadequate from our inspection in October 2022 remains unchanged.

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

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Yes <sup>1</sup>
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• At the previous inspection in October 2022 we found staff including GPs, clinical staff and administration staff had either not completed safeguarding training or training was not to the appropriate level as set out in intercollegiate guidance. At this inspection we saw that all staff had received safeguarding training to the appropriate level as set out in intercollegiate guidance.</li> </ul>	

### Safety systems and processes

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 29 November 2022	Partial <sup>1</sup>
Date of fire risk assessment: Park House Medical Centre: January 2022 Date of fire risk assessment: The Lowdham Medical Centre branch site: October 2020 Actions from fire risk assessment were identified and completed.	Partial <sup>2</sup>
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• <sup>1</sup>At the previous inspection in October 2022 we found the health and safety risk assessments did not demonstrate the level of risks found during the inspection of the branch site at Lowdham. We also found concerns relating to no hot water, inadequate oversight of legionella, electrical safety concerns and the interiors of the building such as holes in ceilings. The practice had addressed some concerns identified at the previous inspection at the Lowdham branch site. At this inspection we found: -The practice had replaced the boiler system in November 2022 following a period of around 11 months without hot water or heating. Despite the replacement boiler there was still outstanding actions relating to legionella. This meant that there was still no hot water being used at the time of our inspection. However, we saw evidence the practice were taking steps to gain assurances</li> </ul>	

of legionella water safety. There was an action plan in place to mitigate risks in relation to a lack of hot water.

The practice were seeking an updated legionella risk assessment and were awaiting results following legionella water sampling. The practice planned to be able to use the hot water by mid December 2022.

- The practice was unable to produce an in date Electrical Installation Condition Report (EICR) at the previous inspection. At this inspection we saw an EICR which was completed in June 2022. We saw the practice had taken steps to address electrical hazards such as wiring hazards.
- The interior of the building required substantial refurbishment to meet infection control guidelines and modernisation. For example, the holes in the ceiling were not able to be repaired due to discontinued tiles and a full ceiling refit would be required. The practice had an action plan and were working with stakeholders to consider options for the future of the building including refurbishment plans and utilising space within the premises.

- <sup>2</sup>At the previous inspection we found concerns relating to fire risk assessments. We were not assured that risks had been identified and actions taken. At this inspection the practice had created an action plan. The practice had taken steps to address these actions such as ordering of blank call points to cover old panels.

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were mostly met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial <sup>1</sup>
Infection prevention and control audits were carried out.	
Date of last infection prevention and control audit: 24/11/2022 Lowdham branch site	Partial <sup>2</sup>
The practice had acted on any issues identified in infection prevention and control audits.	Partial <sup>2</sup>
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Explanation of any answers and additional evidence:

- <sup>1</sup>At the time of this inspection in December 2022 the practice site at Carlton did not have an infection control lead. The leaders were aware and reviewing potential staff who would be suitable. At the branch site at Lowdham there was an appointed infection control lead. However, they had not received extended training for the role.
- <sup>2</sup>At the previous inspection in October 2022 we found concerns relating to the oversight of infection control at the branch site premises including no access to hot water, out of date equipment and cluttered rooms. At the time of our inspection in December 2022 the practice branch site at Lowdham had received an infection control visit by the Integrated Care Board (ICB) on 24 November 2022. The practice had received their report the day prior to our visit and had not been able to review this prior to our visit. Therefore, there was not an up to date action plan.
- The practice had addressed some concerns identified at the previous inspection. At this inspection we found:
  - The practice had replaced the boiler system in November 2022. Despite the replacement boiler there was still outstanding actions relating to legionella. This meant that hot water at the time of our inspection was not able to be used. However, we saw evidence the practice were taking steps to gain assurances of water safety and were awaiting on results from water

sample testing. The practice planned to be able to use the hot water by mid December 2022. Interim measures were in place such as a reduction in services being offered at the site, extra hand sanitising stations.

- We found the practice had replenished out of date stock in clinical rooms and stock rooms including hand washing and cleaning products.
- We found waste was being managed in line with current legislation and advice.
- We found clinical rooms to be visibly clean.
- The practice branch site at Lowdham required extensive refurbishment in areas to improve infection control. For example, decluttering of rooms, removal of carpeting. The providers were in the process of reviewing the layout of the building with action plans in place to address outstanding areas and aesthetics.
- The practice site at Carlton was due to have an infection control visit by the ICB in January 2023. The leaders of both the sites had a date set aside to discuss any actions that may arise and create action plans and updating of procedures and policies.

## Risks to patients

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

	Y/N/Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• At the inspection in October 2022 we reviewed staff training. Staff were not trained in signs of sepsis or medical emergencies. We found not all staff were aware of how to respond to medical emergencies or actions required to take in an emergency. At this inspection we saw that all staff had been reminded of the locations of the medical emergency equipment. We saw that at the branch site the medical emergency equipment had been moved to an accessible location but there was no signage in any clinical rooms advising staff of the location. We reviewed staff training and saw all staff had now received training in sepsis and medical emergencies.</li> </ul>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• At the previous inspection in October 2022 we found there was a lack of process and systems in place for the management of correspondence. At this inspection we found the practice had worked hard to clear the backlog and identified 163 letters outstanding with the letters dating back to the 6 December 2022. We reviewed a sample of letters and saw there was no urgent concerns. We spoke with the practice who confirmed new protocols had been implemented and the practice aim was for all correspondence to be completed within 48 hours. The new protocol enabled effective sharing of information with staff and other agencies to enable safe care and treatment.</li> </ul>	

- At the previous inspection we found concerns relating to delays in referrals which were documented as significant events. At this inspection there had been one incident in relation to referrals which was due to technical error. We saw actions and learning implemented. The practice had also implemented a system to ensure monitoring of referrals which was overseen by clinical leaders.
- At the previous inspection we found the practice had 2182 open tasks which included items marked as urgent. At this inspection we saw that the tasks were 2065. We reviewed a sample and found there was no urgent tasks and all tasks had been created within the past week. We spoke with the providers who explained they were reviewing the way the team operate the system and had created an action plan. The action plan was in progress and the leaders told us it would take time to trial methods and embed systems.

## Appropriate and safe use of medicines

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

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.	Partial <sup>1</sup>
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes <sup>2</sup>
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Partial <sup>3,4</sup>
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li>• <sup>1</sup>At the previous inspection we found there was no formal process for the oversight and monitoring of all non-medical prescribers. At this inspection the practice were holding clinical leadership meetings on a monthly basis. The practice plan was for non-medical prescribers to have supervision quarterly from January 2023. The action plan was for the GP partners at the practice to conduct patient records audits to include note taking, referrals, prescribing and outcomes. The practice plan to hold clinical supervision meetings to discuss the outcomes of the audits.</li> <li>• <sup>2</sup>At the previous inspection we found that there was no process or clear audit trail for the management of information changes to patients' medicines. At this inspection we found that the practice had analysed the searches from the previous inspection. The leadership team had investigated the cause and found that the team did not always document information collaboratively resulting in information not always being immediately visible. The practice held a clinical meeting to discuss a new protocol of the inputting of changes to patients' medications and requests would now be documented into the patient medical record by all staff creating a streamlined way of working. The practice were in the early stages of changes and of the five records we reviewed we found no concerns.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>• <sup>3</sup>At the previous inspection we found concerns relating to the monitoring and storage of vaccines. At this inspection we found the vaccine refrigerator was overstocked and did not allow for 2 to 3 inches between vaccine containers and the refrigerator walls. Vaccines may lose their effectiveness if they get too hot or cold with no circulation around them.</li> <li>• <sup>4</sup>At the previous inspection in October 2022 we saw instances where the fridge temperature had been recorded above the maximum temperature with no assurance that actions had taken place to ensure the vaccinations remained safe and effective. At this inspection the practice had purchased a data logger for inside the fridge, but this was not fully working at our inspection. However, we spoke with the practice leaders and saw records of the recordings of the fridges and saw that temperatures had remained in range. Staff had been reminded of the protocol to take if the fridge temperatures reached above the maximum temperature.</li> </ul>	

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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	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:	5 recorded since our last inspection
Number of events that required action:	5
Explanation of any answers and additional evidence: The practice leadership had developed and implemented a new significant event system. This included a comprehensive document which linked all the stages together in one document. Staff could now easily access significant events and see the stages of investigation and learning.	

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

Event	Specific action taken
Task sent through to the practice over a weekend from secondary care. Request of a home visit delayed by three days.	<ul style="list-style-type: none"> <li>• Investigation by the practice leadership into how this occurred including reviewing of the clinical system.</li> <li>• Investigation revealed error of how the task was sent. Contact made to secondary care to raise incident and to pursue further learning to include change in processes.</li> <li>• Staff alerted and learning cascaded.</li> <li>• Discussed in clinical leadership meetings.</li> </ul>
Incorrect referral sent due to technical error	<ul style="list-style-type: none"> <li>• Incident investigated by the practice leadership team which resulted in identifying technical difficulties.</li> </ul>

	<ul style="list-style-type: none"> <li>• Learning cascaded to all staff members.</li> <li>• Discussed in clinical leadership meetings.</li> </ul>
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At the previous inspection in October 2022 we found the system for recording and acting on alerts was ineffective and there was concerns regarding the management of patients' safety alerts. At this inspection we found that the management of patient safety alerts had been addressed. Leaders at the organisation took overall responsibility for checking alerts with clinical oversight for assurance that alerts were dealt with appropriately.</li> <li>• At the previous inspection in October 2022 we found the provider was unable to demonstrate that all relevant safety alerts had been responded to. At this inspection we reviewed five records following a safety alert of patients childbearing age prescribed a medication. We found all patients had been reviewed by the practice. Three patients were no longer taking the medication and two patients had been invited into the practice to discuss potential risks associated with taking the medication.</li> </ul>	

## Effective

## Rating: Inspected not rated

At the inspection in October 2022, we found areas of concern that impacted on effective patient care. This key question was rated as Inadequate and this was due to:

- The practice could not demonstrate they had systems and processes to keep clinicians up to date with current evidence-based practice.
- Patients with long-term conditions or potential long-term conditions had not received up to date monitoring and review.
- Not all staff had completed training required for their role.
- Staff did not always work together and with other organisations to deliver effective care and treatment.
- Patients did not have access to appropriate health assessments and checks.

This inspection in December 2022 was not rated and therefore the rating of inadequate from our inspection in October 2022 remains unchanged.

### 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.**

### Effective care for the practice population

#### Findings

At the previous inspection in October 2022 we found there was not always effective care for the patient population.

- In October 2022 we conducted remote clinical searches of patients prescribed a short-acting bronchodilator (SABA or reliever) inhaler who had been prescribed 12 or more inhalers to review potential over usage or unstable asthma. We reviewed 5 patient records, none of which were reviewed in line with national guidance, including consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. At this inspection we reviewed 5 patients' clinical records identified at the previous inspection and saw that all had received a review in line with national guidance, considerations of treatment options and where needed referrals.
- In October 2022 we found that the practice did not always issue a steroid card to patients when deemed appropriate. Since this inspection the practice has held meetings with clinicians and leaders of the practice to discuss the guidelines with all team members to ensure everyone is aware. We were told by the provider that all the GPs at the practice had worked overtime during weekends to review patients and issue warning cards where appropriate.



## Management of people with long term conditions

### Findings

At the previous inspection in October 2022 we conducted searches on the practice patient clinical record system regarding the management of patients with long term conditions. We found that patients were not always reviewed to ensure their treatment was optimised in line with national guidance.

- In October 2022 we conducted a remote clinical search of patients with thyroid disease. The search revealed 25 patients out of 402 with thyroid disease that were not reviewed to ensure they could be offered treatments or monitoring to improve control. We found there was no clear process in place to recall these patients. At this inspection in December 2022 we conducted the same search which revealed 21 patients out of 404 with thyroid disease. We reviewed 5 patients' clinical records and saw 3 had received blood tests since our inspection and monitoring was now up to date and 2 patients had been contacted by the surgery to book in for monitoring. We spoke with the practice who confirmed they had begun recalling all patients and had inputted new recall systems to ensure patients were invited for regular monitoring.
- In October 2022 we conducted a remote clinical search of patients with poorly controlled diabetes. The search revealed 72 out of 728 patients who had potentially not received a review. We reviewed 5 records and found there was no clear pathway to ensure patients were not missed for reviews. At this inspection we conducted the same search which revealed a reduction to 66 patients. We reviewed 5 patients' clinical records and all 5 patients had been contacted and had received an up to date review by the practice team including the diabetic specialist nurse.
- In October 2022 we conducted a search of patients diagnosed with Chronic Kidney Disease (CKD) stage 4 or 5 who had potentially not received monitoring in line with national guidelines. The search revealed a potential 18 of 25. At this inspection we conducted the same search which revealed a reduction to 6 patients. We reviewed 6 patients' clinical notes and found 2 were receiving care from secondary services, 1 was coded in error. Of the 3 records remaining all had been contacted and invited to attend the practice for monitoring.

### 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• At the inspection in October 2022 we reviewed staff training. Whilst we received evidence post inspection of training that had been completed, we found there was a lack of oversight of staff knowledge, training and competency checks. Staff were not trained in signs of sepsis and safeguarding. At this inspection we saw that all staff had received training in sepsis and safeguarding.</li> </ul>	

- At this inspection we saw that there was oversight of staff training, staff were emailed by the leadership team if training was due.
- Staff were given protected time for learning and development or if requested an option for overtime was given.
- The practice team had worked hard to complete training courses in a short period of time.

## Responsive

## Rating: Inspected not rated

At the inspection in October 2022 this key question was rated as Inadequate and this was due to:

- Patients were unable to access care and treatment in a timely way.
- Patient feedback directly to CQC was negative regarding the telephone systems.
- Patient feedback directly to CQC was negative regarding being able to access care.
- Many of the national survey indicators published in July 2022 was significantly lower than local and national averages.
- The facilities and premises were not appropriate for the services being delivered.
- Complaints were not used to improve the quality of care.

This inspection in December 2022 was not rated and therefore the rating of inadequate from our inspection in October 2022 remains unchanged.

### Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year. (Since previous inspection October 2022)	4 since previous inspection
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• At the previous inspection we found concerns relating to the management of complaints. In particular complaints not being responded to, complaints being misplaced, and evidence of actions taken by the practice not available. At this inspection we found the practice now had effective system in place for the oversight of complaints. The practice had appointed trained leaders to deal with complaints.</li><li>• All staff had been reminded of the complaint's procedure in staff meetings and staff bulletin emails.</li><li>• The practice leadership team used a system which included all information relating to the complaint to include acknowledgement, responses and actions taken.</li><li>• The practice were also documenting verbal complaints to monitor themes and learning opportunities.</li></ul>	

Example of learning from complaints.

Complaint	Specific action taken
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Misunderstanding with appointment system	<ul style="list-style-type: none"><li>• Investigation by practice leaders.</li><li>• Apology given to the patient and explanation provided.</li><li>• Discussed at meeting</li></ul>
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## Well-led

## Rating: Inspected not rated

At the inspection in October 2022 this key question was rated as Inadequate and this was due to:

- Leaders could not demonstrate they had the skills and/or capacity to deliver high quality sustainable care.
- Governance processes were ineffective.
- Processes for managing risks were poor.
- There was not always a supportive and open culture.
- The practice did not always act on appropriate and accurate information.
- The practice did not have clear and effective processes for managing risks, issues and performance.

This inspection in December 2022 was not rated and therefore the rating of inadequate from our inspection in October 2022 remains unchanged.

### Leadership capacity and capability

**Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• <sup>1</sup> At the previous inspection we found due to absences in leadership there had been at times periods of ineffective leadership. At this inspection we found that leaders had returned and that the practice remained stable.</li><li>• Following our inspection in October 2022 the practice had addressed areas that required immediate action and had started to implement changes. The practice leaders were aware that this process would take considerable time and effort.</li><li>• The practice leaders had worked hard to address challenges found at the previous inspection in relation to governance systems. We saw areas where the practice had improved such as complaints, significant events and staff training. The practice were aware of further improvements needed in relation to oversight of areas such as the building at the branch site.</li></ul>	

### 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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Explanation of any answers and additional evidence:	

- At the previous inspection we found the practice was unaware that some of their systems and processes were ineffective such as medicine reviews, safety alerts, risk assessments and audits. At this inspection we found that the practice had created action plans for all areas of concerns. The practice were holding monthly meetings with the leaders at the practice. The meetings followed an agenda where protocols, audits and new processes were implemented and discussed. We saw that the areas of concerns highlighted in the searches at the previous inspection were being actioned by the team.
- The practice team had worked hard to action many of the backlogs found at the previous inspection. The practice team had created new protocols to ensure backlogs relating to correspondence do not occur in future. The practice clinical team had worked overtime and during weekends to contact patients who required reviews. Despite their best efforts there was still areas where patients needed to receive reviews. The practice planned to have all backlogs and patients seen within six-month period. The action plans gave realistic targets and actions that the practice would take to ensure that backlogs would not occur in future.

## Managing risks, issues and performance

**practice did not always 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.	Partial <sup>1</sup>
There was a quality improvement programme in place.	Yes <sup>2</sup>
There were effective arrangements for identifying, managing and mitigating risks.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial <sup>3</sup>
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• <sup>1</sup> At the previous inspection we found that the practice did not have comprehensive assurance systems in place. For example, in relation to health and safety concerns relating to the premises at the Lowdham branch site. At this inspection we saw that assurance systems had been implemented around the overall health and safety and some improvements had been made. However, there was still areas outstanding relating to legionella and infection control. The practice were working with other stakeholders to improve the premises.</li> <li>• <sup>2</sup> At this inspection we were provided with multiple action plans and quality improvement was a driving force within the practice leadership.</li> <li>• <sup>3</sup>At the previous inspection we found the premises at the Lowdham branch site required substantial refurbishment in order to improve the quality of care for patients. At this inspection we saw the practice were taking steps to address this. For example, new boilers had been installed however the practice were awaiting assurances on legionella safety which included restarting the use of the hot water. Areas were still outstanding such as holes in the ceiling, rooms requiring refurbishment in line with infection control standards.</li> </ul>	

## 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>At this inspection we found that the practice had started using data in new areas to monitor and improve correspondence management. For example, the practice leadership team were auditing samples of clinical correspondence that was managed by each staff member. The audit provided percentages of accuracy, this enabled the leadership team to identify areas of improvements, potential significant events and training development opportunities.</li> <li>At this inspection the practice was holding clinical leadership meetings on a monthly basis. The practice plan was for non-medical prescribers to have supervision quarterly from January 2023. The action plan was for the GP partners at the practice to conduct patient records audits to include the note taking, referrals, prescribing and outcomes. The practice plan to hold clinical supervision meetings to discuss the outcomes of the audits.</li> </ul>	

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

**Glossary of terms used in the data.**

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.