

Care Quality Commission

Inspection Evidence Table

Rough Hay Surgery (1-2655736222)

Inspection date: 15 November 2022

Date of data download: 21 October 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The practice demonstrated an effective process of ensuring safeguarding was a key part of patient care. Safeguarding was a standing item on the practice meeting's agenda and concerns were discussed with staff to ensure all staff were aware of any concerns.• Alerts were also added to patient records to highlight safeguarding concerns.• The practice had policies and processes to support staff in this area and staff were clear on how they accessed these policies.• Staff had completed safeguarding training relevant to their role.• Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks were in place for staff as part of pre employment checks. This included enhanced and standard DBS checks based on the role and responsibilities of the job. DBS checks identify whether a person has a	

Safeguarding	Y/N/Partial
<p>criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.</p> <ul style="list-style-type: none"> The practice told us that to access the health visiting team they needed to use a single point of access number to speak with them. Since the COVID-19 pandemic, no multi-disciplinary team meetings had been held. The practice said they had requested that these start again. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We looked at a range of recruitment files which included both clinical and administrative employed staff and found recruitment checks in place. This included immunisation status and DBS checks. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 25 July 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: 25 July 2022 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Evidence provided by the practice showed equipment was regularly calibrated and electrical items were PAT (Portable appliance testing) tested. Fire safety policies were in place and evidence was provided of a completed fire risk assessment. The practice had carried out a range of health and safety risk assessments. An action plan was in place and evidence was provided that actions were being completed. For example: To display clear and effective signage of any potential hazardous substances. All staff had completed fire safety training. Systems were in place for the regular checks of fire alarms, extinguishers and fire evacuation procedures. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y

Date of last infection prevention and control audit: September 2022	
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> All staff completed the relevant infection control training for their role through the online training system in place. The practice had an action plan in place to address concerns identified during the infection control audit. For example: A small amount of debris was found on the underside of the soap dispenser in the patient's toilet. The practice had informed the cleaner to ensure that these areas were cleaned effectively. Policies, procedures and audit templates were in place for infection prevention and control and accessible to all staff. We observed the general environment to be visibly clean and tidy. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Staff had completed sepsis awareness training and had access to emergency medicines if required. The practice had recently employed a practice nurse to provide extra appointments. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹	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.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We found 14 boxes of patients' records awaiting summarising. The leadership team were aware of the backlog and had increased the hours of staff who carried out the role of summarising to try and reduce the number of records. We were also told that the practice had approached the Primary Care Network (PCN) for support on actioning this backlog. Staff we spoke with told us that they were aware of the backlog, however they could not confirm how old the records were. This posed a potential risk as clinical staff would not have up to date records available when seeing patients. Following the inspection, we received evidence to demonstrate that 93.4% of records had been summarised. A policy was provided which showed clear guidance on the actions that staff were required to take to ensure records were actioned appropriately. The practice had a system in place for the management of referrals under the two week wait process. Monitoring processes were in place to identify patients who were referred using the two week pathway and to ensure the pathway was used appropriately. 	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	1.33	0.83	0.82	Variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	7.6%	6.1%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets	4.43	5.20	5.31	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	241.0‰	139.0‰	128.0‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>	1.66	0.66	0.59	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	15.5‰	8.7‰	6.8‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement 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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y

Medicines management	Y/N/Partial
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence, including from clinical searches.	
<ul style="list-style-type: none"> • The practice had historically been high prescribers of antibiotics, but had implemented an audit to review their prescribing and action plan to reduce the number of antibiotics issued. A target template had been implemented with a treatment plan and guidelines. • The review of clinical records showed 36 patients had been prescribed medicines for nerve pain. We reviewed a random sample of five records which showed all patients were overdue monitoring. Information recorded in each patient record showed that patients had been contacted to attend for a review. • There was clinical oversight for all requests for medicine changes and a clear process was in place to demonstrate what actions had been taken. • We carried out random searches of patients prescribed high risk medicines and on reviewing a sample of patients' records we found prescribing was in line with guidelines and regular reviews were in place. • Emergency medicines and vaccines were appropriately stored and there were clear monitoring processes in place. • On reviewing a random sample of patients records we found medicine reviews had been completed and well documented. 	

Track record on safety and lessons learned and improvements made

The practice did not 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.	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.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	1
Number of events that required action:	1
Explanation of any answers and additional evidence:	

- We found the practice did not have an effective system in place for the recording of significant events. The current system needed strengthening to ensure all incidents and events were captured and discussed as part of shared learning. Following the inspection, we received evidence to demonstrate the practice had implemented an action plan to ensure all significant events and incidents were recorded, analysed and acted on.
- We spoke with a range of staff who were aware of who to report incidents to, however the leadership team had identified that further training was needed to ensure staff knew what an incident or significant event was. At the time of inspection no plans were in place to implement the training. Following the inspection, we received evidence to demonstrate that staff had completed training on incident reporting processes.
- Staff meetings were held on a regular basis and any incidents or events were shared with staff. During the inspection we identified an incident that had not been recorded, so we were unable to gain assurances that learning was effective to mitigate future risk.

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

Event	Specific action taken
Oxygen needed by patient	<ul style="list-style-type: none"> • Nebuliser was used to provide oxygen for a patient who attended the practice, whilst waiting for ambulance. Ambulance was delayed, oxygen cylinder was used completely. • New oxygen cylinder ordered. • The learning from the incident was shared with the practice team.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider was able to demonstrate that all relevant safety alerts had been responded to. We reviewed a safety alert concerning a medicine used for the retention of fluid and that patients on this medicine had an increased risk of skin cancer. We found 3 patients on this medicine and on reviewing each clinical record we found two patients had been changed to another medicine, however one patient had not been made aware of the potential risk. We shared our findings with the clinical lead and received assurances that medicine reviews would be carried out.</p>	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• On reviewing the clinical system, we found five patients with hypothyroidism that had not had the appropriate monitoring done in the past 18 months. We reviewed each of the five records and found that the patients had been contacted on several occasions by the practice to attend for review.• We saw care plans to drive forward patient care in areas such as learning disability reviews were in place.• The practice used a range of clinical templates to support the management of patients' conditions, which linked in with the latest clinical guidance.	

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.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- On reviewing the asthma register we found 27 patients who had been prescribed two or more steroids in the past 12 months. We reviewed a random sample of five clinical records and found patients had been followed up appropriately.
- 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 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,	45	49	91.8%	Met 90% minimum

Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	33	41	80.5%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	32	41	78.0%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	33	41	80.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	46	57	80.7%	Below 90% minimum

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

Any additional evidence or comments

- A number of children were frequent non-attenders to appointments. The practice had been unable to organise meetings with the health visiting team to discuss these children, however they had contacted the health visiting team to try and organise future meetings to share this information.
- The practice told us they had been trying to recruit a practice nurse without success for a number of months, however they had recently employed a practice nurse and plans were in place to increase appointments to improve childhood immunisation targets.
- The nurse prescriber had prioritized childhood immunisations to offer more availability and encourage patients to attend their appointments.
- Following the inspection we received unverified data which showed that between April and November 2022 the practice had achieved 90% for children aged 2 who had received PCV, Hib/ MenC booster and MMR.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified	65.7%	N/A	80% Target	Below 70% uptake

period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	67.4%	55.8%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	50.4%	57.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	46.2%	50.3%	55.4%	No statistical variation

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

Any additional evidence or comments
<ul style="list-style-type: none"> Patients could access weekend clinics through the out of hours provider for cervical screening, if they were unable to attend the practice during opening hours. The nurse prescriber had prioritized cervical screening and was doing extra sessions to provide appointments in the absence of a practice nurse. Text messages were sent out to patients with information about the screening service and the contact details of how to book appointments.

Monitoring care and treatment

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

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

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

The practice shared with us an audit they had completed to assess the prescribing of antibiotics in children aged 0-10 years during the month of March 2022. The audit identified 10 patients who had been prescribed antibiotics in this age group. A total of 9 patients had been prescribed within the appropriate guidelines and one patient had been prescribed more days than recommended. A plan was in place to review the audit again in six months time to ensure prescribing of antibiotics was in line with recommended guidelines.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Quality standards along with other information such as complaints were discussed at staff meetings. Staff were very positive about working at the practice. Staff told us they received regular support from the management team. Staff had clear roles and responsibilities and received regular appraisals. A system was in place to monitor and review staff training and we saw high levels of completion rates for training specified as mandatory by the provider for staff. This included level three training for clinical staff in safeguarding. Discussion with clinical and non-clinical staff demonstrated awareness and understanding in areas such as safeguarding and responding to an emergency. 	

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.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Explanation of any answers and additional evidence:

- The practice held palliative care meetings on average every two months. We were told that invitations were sent out to community teams, however uptake was poor. The practice continued to send out invitations to encourage community teams to attend.

Helping patients to live healthier lives

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

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

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.	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. ¹	Y

Well-led

Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The leadership team were aware of the challenges and had a realistic strategy and supporting objectives to respond to challenges as well as maintaining quality and sustainability. Regular meetings were held with staff to discuss improvements and share ideas.• Staff we spoke with explained that the leadership team were visible and approachable. Staff described the practice team as supportive. The leadership team demonstrated a passion to tackle health inequalities and there were strong governance arrangements in place to improve care outcomes.• Staff reported that they felt well led and part of a team. There was strong collaboration and support across the team and a common focus on improving the quality of care and people's experiences.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The practice had a mission statement which staff were aware of. The practice aimed to provide high quality care to all patients in a compassionate, confidential and timely manner, whilst offering choice and involvement.• Staff we spoke with demonstrated clear understanding of the practice vision, value and strategy and applied this in their role.	

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.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice tried to mitigate possible future risks by discussing incidents and complaints at staff meetings to share learning. Staff were very positive about working at the practice. Staff told us they had received constant support from the GPs, manager and team. There was a positive attitude throughout the entire workforce which enabled the smooth running of the practice. Staff had clear roles and responsibilities and staff wellbeing was discussed as part of the appraisal process. 	

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

Source	Feedback
Staff	We spoke with a variety of staff during the inspection and were told everyone was part of the team, the leadership team were very supportive and approachable.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	

- The practice had systems in place to ensure all staff were clear on their roles and responsibilities. Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place.
- Communication was effective and organised through structured, minuted meetings. Governance and performance management arrangements were proactively reviewed and reflected best practice.
- The practice had systems in place to ensure all staff were clear on their roles and responsibilities. Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had implemented a range of quality improvements. Audits were carried out in a range of areas to monitor the services provided. • The provider had undertaken several risk assessments relevant to the provision of clinical care, including infection control and premises risk assessments. Recommendations from risk assessments had been actioned. • The practice had a significant event policy in place, however we found that the recording of significant events and incidents needed strengthening to ensure future risk was mitigated. The leadership team told us they were aware that this needed improvement and had plans to implement processes for the recording and sharing of learning within the practice team. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y

Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice used clinical audits to drive performance and demonstrate improved outcomes for patients. A range of safety mechanisms had been implemented to ensure risks were mitigated. This included a range of risk assessments to ensure patient safety. 	

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
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We found outstanding patients' records awaiting summarising. On reviewing the premises, we found 14 boxes of notes that had not been reviewed. We were told that staff who carried out the role of summarising had received an increase in hours to help reduce the number of records waiting and the leadership team had requested support from the primary care network. Following the inspection, we received evidence to demonstrate that 93.4% of records had been summarised. A policy was provided which showed clear guidance on the actions that staff were required to take to ensure records were actioned appropriately. There were policies in place to support staff with utilising digital services securely and effectively. Online consultations took place in consultation rooms with the doors closed to protect the patients' privacy. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had an active patient participation group. We were told that there were currently five members in the group. Meetings had recommenced following the COVID-19 pandemic. • Regular staff meetings were held to share ideas and discuss new initiatives. • The practice used the friends and family test to gather patient feedback. The latest results provided showed that during the month of October 2022, 39 patients had completed the test and 38 patients had said they were extremely likely/likely to recommend the practice. 	

Feedback from Patient Participation Group.

Feedback
We spoke with two members of the patient participation group who told us that the practice shared information with them regularly. The group felt they were listened to.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • An effective process was in place to ensure all staff were up to date with the practice's mandatory training. Staff told us they were given the opportunity to develop and learn. • Learning from events needed strengthening to ensure all incidents and significant events were reported and shared to enable lessons to be learnt and improvements to services were implemented. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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