

Care Quality Commission

Inspection Evidence Table

Forest Health Group (1-572215550)

Inspection date: 26 October 2021

Date of data download: 04 October 2021

Overall rating: Good

At our last inspection in May 2019 we identified risks and breaches of regulations. These led to the practice receiving a rating of Requires Improvement in three key questions (safe, effective and well-led) and overall. The risks included a lack of monitoring of training and poor operation of systems and processes.

Safe

Rating: Requires Improvement

At our last inspection in May 2019, we identified risks associated with a lack of training in infection control, management of risks including fire and legionella and other concerns.

At this inspection, action had been taken to improve the safety of the service. However, not all associated health and safety actions had been completed due to the pandemic, outsourced facilities management of one site and staff changes. The practice was in the process of completing these actions.

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

Safeguarding	Y/N/Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we looked at the training matrix and not all staff had completed their safeguarding adults and children to the required level, although they were able to demonstrate suitable knowledge in the area.</p> <p>At this inspection we were shown the training matrix and all safeguarding training was to the required level and in date.</p>	
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 Public Health England (PHE) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we found that not all clinical staff had a record of vaccination as required by their roles and related assessments.</p> <p>At this inspection we identified that recruitment processes had been improved. There were records to demonstrate appropriate vaccination of staff for .</p>	
Safety systems and records	Y/N/Partial
<p>Health and safety risk assessments had been carried out and appropriate actions taken.</p> <p>Date of last assessment: March 2021</p>	Y
There was a fire procedure.	Y
<p>Date of fire risk assessment:</p> <p>Boundary House 17/11/16</p> <p>Skimped Hill Health Centre 05/12/19</p> <p>Ringmead site 08/01/18</p>	Partial

Explanation of any answers and additional evidence:

At our previous inspection we identified that risks related to legionella and fire associated risks were not always identified, assessed and mitigated.

At this inspection we found actions from fire risk assessments and legionella checks were identified and completed at two sites. However, the Skimped Hill site was managed by another company under a tenancy agreement and Forest Health Group did not have oversight of all the fire safety risk assessments, equipment checks and risk assessments for legionella. At this inspection we were shown evidence that Forest Health Group had copies of all fire safety risk assessments and checks on fire equipment for all sites. The risk assessments had been undertaken in recent years and had all had been reviewed in 2021. We were also shown evidence that Forest Health Group had asked for any changes identified in the fire safety and legionella risk assessments be completed by the management company and they had repeated their request throughout 2021. Some had been completed and while others remained in progress.

We saw one fire risk (no signage indicating where oxygen is stored) was not identified in the risk assessments. The practice installed these warning signs immediately after the inspection. The new practice manager had undertaken a comprehensive health and safety risk assessment including assessment of fire risks, with an appropriate contractor, in the weeks prior to our visit. The report was received during the inspection. The risk we identified during inspection was found in this assessment, as well as others. The practice had undertaken this risk assessment to ensure they understood all the potential gaps in the previous risk assessments undertaken and provide assurances that the sites were safe to operate. We received assurances any residual action would take place in the coming weeks, and the practice acknowledged some of these risks had not yet been identified and therefore acted on to date.

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. Date of last infection prevention and control audit: Boundary House 24/05/21 Ringmead Site 24/05/21 Skimped Hill 05/07/21	Y
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
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we found that not all staff had completed up to date training in infection control. At this inspection we looked at the training matrix and all staff were up to date with this training.</p> <p>The practice undertook measures during the pandemic to reduce the risk posed by Covid. This included more virtual consultations, improved PPE measures and increased cleaning processes.</p>	

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

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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
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

Appropriate and safe use of medicines

The practice had did not always have systems for the appropriate and safe use of medicines, but did ensure appropriate medicines optimisation and monitoring of repeat prescribing.

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)	0.59	0.63	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)	9.7%	10.8%	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)	6.05	5.56	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	84.1‰	71.8‰	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)	0.37	0.63	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	5.8‰	5.4‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	N
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

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.	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.	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.	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 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.	Y
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
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 PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>When we reviewed the system for logging the usage of paper prescriptions, we found the practice did not always ensure prescriptions were logged appropriately to ensure a clear audit trail was in place. All scripts we reviewed belonging to the practice were stored securely. Due to our finding the practice launched an immediate audit of all paper prescriptions logged at all sites. They identified and reported openly to CQC where they identified the system was not being operated appropriately. They began a process of accounting for all the prescriptions currently in use to ensure they could account for any discrepancies. The practice has since confirmed they have implemented a more secure and auditable policy immediately for all sites, with a review date set for within 12 months. However, this was only identified due to the inspection and was not independently monitored appropriately by the practice prior to this CQC finding.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
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:	16
Number of events that required action:	16

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

Event	Specific action taken
A child was offered a vaccination but a sibling wasn't due to an inaccuracy on the patient's medical record. No harm was caused.	The practice looked into the issue and found that the medical record had been incorrectly updated from a hospital letter. The practice apologised for the error and amended the medical record. No further action was needed.
A patient taking pain medication asked for their dose to be increased. The patient was told they could increase the dose but this was later found to be inappropriate prescribing.	Investigation showed although the patient had been told they could increase their dose they hadn't been told the maximum amount they could take per day. The practice recognised the importance of being clear when advising patients of medication doses and timings.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y

Effective

Rating: Good

At our last inspection in May 2019 we identified risks associated with a lack of training.

At this inspection we found there was a system to monitor and deliver staff training needs.

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.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	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 had prioritised care for their most clinically vulnerable patients during the pandemic	Y

Effective care for the practice population

Findings
<ul style="list-style-type: none">• Vaccinations against conditions such as flu, shingles and pneumonia among others, were offered to relevant patients (defined medical conditions or by age group).• Patients with a learning disability were offered an annual health check. The practice identified that they were behind on achieving all annual health checks within the yearly cycle. Therefore, an action plan was implemented including staff resources to ensure the health checks were undertaken by the end of the year. The plan was still in progress at the time of the inspection.• End of life care was monitored and reviewed including records of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms.

- Information regarding how to manage fevers (high temperatures) in children was provided to parents/guardians when needed.
- The practice assessed and monitored the physical health of people with mental illness and depression.

Management of people with long term conditions

Findings

- The practice identified the need to improve diabetes care and performance in this area compared with national averages. They implemented an action plan including a diabetes qualification for a GP diabetic lead, working with local diabetes experts and created a communications channel for staff to share best practice and concerns regarding patient care. The practice also implemented a different system for patients to book diabetic checks. In March 2021, numbers of non-frail patients with HbA1c 58 mmol/L (a measurement and indicator used to determine the blood glucose levels of patients over a long period of time) was 49%. By October 2021, following the implementation of the action plan, numbers of non-frail patients with HbA1c < 58 mmol/L was 65%
- We undertook searches on the clinical record system. We found:
 - Patients with poorly managed diabetes were followed up to assess risk factors and provide care and advice as required.
 - Patients with chronic kidney disease were monitored.
 - Patients who were at risk due to their asthma condition were monitored appropriately.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of their condition. A lead GP informed us this would be delegated to the appropriate condition depending on the concern.
- The practice had an action plan to begin undertaking spirometry (used to diagnose and monitor chronic obstructive pulmonary disease (COPD) but suspended during COVID due to aerosol contamination risks). This enabled monitoring of patients with COPD and reduced the risks of exacerbation of the condition.

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	214	220	97.3%	Met 95% WHO based target

doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)				
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)	216	226	95.6%	Met 95% WHO based target
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)	218	226	96.5%	Met 95% WHO based target
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)	218	226	96.5%	Met 95% WHO based target
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)	242	259	93.4%	Met 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>

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) <small>(Public Health England)</small>	71.7%	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) <small>(PHE)</small>	76.6%	71.0%	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) <small>(PHE)</small>	60.4%	62.2%	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) <small>(PHE)</small>	51.6%	47.1%	54.2%	No statistical variation

Any additional evidence or comments

The practice recognised that the numbers of cervical screening undertaken for eligible patients had declined during the pandemic as a result of national lockdowns. They undertook action to improve the uptake including offering extra screening 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

An audit into the monitoring of vitamin B12 in patients prescribed medicines containing Metformin (used to treat diabetes) had been undertaken in February and October 2021. In February 2021, less than 20% of patients had recorded monitoring of B12 in the last three years. By October 2021, this had increased to 50%.

The practice ran an ongoing DOAC (direct oral anti-coagulant) medication audit. This monitored the prescribing and reviews of patients prescribed these medicines.

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> <p>At our previous inspection we found staff were not always up to date with their mandatory training.</p> <p>In October 2021, we found significant improvements to training and development. We saw evidence that the practice had a comprehensive induction programme which included an allowance for staff to complete all their mandatory training in the first week of employment and before they begin their duties. We were shown the training log which indicated all staff were up to date with their training. We were told that appraisals took place yearly and for staff in their probation, there were regular performance discussions and mentors to support them.</p> <p>Staff told us they were able to complete training in specialist areas of interest. They felt supported in their professional development.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y

Patients received consistent, coordinated, person-centred care when they moved between services.	Y
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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
Explanation of any answers and additional evidence: The practice employed a social prescriber to help people live healthier lives. Social prescribing is a way that local agencies such as GP services can refer someone to specific community services and schemes which may help with health and wellbeing.	

Consent to care and treatment

The practice had systems to obtain consent to care and treatment in line with legislation and guidance.

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

Well-led

Rating: Good

At our last inspection in May 2019 we identified governance processes were not always operated appropriately and risks to patients were not always identified and mitigated.

At this inspection, we found action had been taken to identify, assess and mitigate risks. Governance systems had improved. There was extensive quality improvement work underway to improve the experience of services and care for patients.

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

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

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

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

Source	Feedback
Staff interviews	Staff we spoke with felt supported by leaders. They felt able about reporting concerns and knew how to report any incidents they encountered which required potential investigations.

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
Explanation of any answers and additional evidence: At our previous inspection we found that governance systems were not always operated consistently. At this inspection we found the practice had implemented improvements to their governance systems and clinical quality improvement processes. The non-clinical governance of the practice had been hindered by the resignation of the previous practice manager in early summer 2021. This delayed certain improvements which were underway. A new practice manager began work in October 2021. They had been proactive in reviewing risks and governance arrangements, making improvements where they deemed necessary.	

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.	Partial
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.	Y
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:	
At our previous inspection we found that risks were not always identified, assessed and mitigated.	
At this inspection we identified improved systems for monitoring risks to patients. Risk assessments had been undertaken and some actions completed where risks had been identified. This was ongoing and the practice had identified the need to implement a more holistic comprehensive risk identification process. As a result, a new comprehensive premises risk assessment was being undertaken at the time of inspection with additional actions in place to improve safety for patients.	
Assurance systems regarding clinical care were in place to identify where improvements were required. For example, where the pandemic had affected the ability to provide some care to patients, there were action plans to mitigate these risks.	
The practice did not identify that there were risks associated with paper prescription usage. When this was identified during the inspection, immediate action was taken to review the system over all three sites. A new system was implemented immediately and the practice reported the findings from their audit of the previous system openly to CQC, highlighting the concerns they found.	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y

There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y

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

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

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: The practice identified poor feedback from patients about the availability of appointments from a variety of sources including GP Patient Survey data and an NHS website where patients can leave reviews. In response it completed a survey and planned several projects to improve patient satisfaction including changes to the responsibilities of each clinical role and new guidance about what type of appointments should be allocated to each clinician. The practice identified efficiencies in the handling of certain tasks which did not require clinical input. As a result, there were improved systems for ensuring reception could handle such work, freeing up more clinical resource. Due to feedback about phone access, the practice recruited more reception staff and provided additional training to existing staff which reduced the answering time from six minutes, nine seconds in June 2021 to four minutes, 31 seconds in October 2021. The survey and patient feedback identified there were not enough appointments available at times. In response the practice provided a Saturday clinic in September 2021 and saw 250 patients in one day. Another clinic was going to be held in the future.	

Feedback from Patient Participation Group.

Feedback
We received feedback from the PPG. They were complimentary about the practice's inclusion of the group in the running of the practice. They felt their care as patients was positive.

Continuous improvement and innovation

There were 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.	Y

Examples of continuous learning and improvement

- The practice identified the need to improve diabetes care and performance in this area compared with national averages. They implemented an action plan including a diabetes qualification for a GP diabetic lead, working with local diabetes experts and created a communications channel for staff to share best practice and concerns regarding patient care. The practice also implemented a different system for patients to book diabetic checks. In March 2021, numbers of non-frail patients with HbA1c ≥ 58 mmol/L (a measurement and indicator used to determine the blood glucose levels of patients over a long period of time) was 49%. By October 2021, following the implementation of the action plan, numbers of non-frail patients with HbA1c < 58 mmol/L was 65%.
- During the pandemic the practice added a carer registration process to their website. They encouraged access for carers via the digital portal and enabled prescription requests to be submitted via the telephone to make the process easier. They also encouraged carers for patients, particularly those caring for patients with learning disabilities, to register via social media.
- We were shown results of an anonymous staff survey. This identified that while many teams felt there was a positive culture and they were well supported by leaders, the reception team needed some support to improve culture and performance. The analysis identified that the receptionists were finding their role challenging at times and this was affecting their moral. Factors included a minority of patients' behavior towards staff, workload and pay and conditions. To improve this the practice was commissioning workshops to explore team dynamics and how wellbeing and performance could be improved in the reception team. The management stated in its action plan it was committed to continuing this work with the reception team after the workshops to ensure the changes were embedded.

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 practices 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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- % = per thousand.