

# Care Quality Commission

## Inspection Evidence Table

### Park Health Care Centre (1-5612635590)

(Also known as DELTA Healthcare)

Inspection date: 06 and 08 December 2021

Date of data download: 05 November 2021

## Overall rating: Good

At the last inspection in August 2019 the practice was rated as requires improvement because improvements were needed to ensure care was safe and effective. We made a number of recommendations for improvement. We saw at this inspection in December 2021 that these recommendations had been followed and the required improvements had been made. The practice is therefore now rated as good overall and for safe and effective care.

## Safe

## Rating: Good

At the last inspection in August 2019 the practice was rated as requires improvement for safety as improvements were needed in a number of areas, such as safeguarding, the logging of prescription stationary, the system for disseminating safety alerts in the practice, and recruitment processes. At this inspection, we saw that improvements had been made and the practice is now rated as good for safety.

### 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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At the inspection in August 2019 we saw that some staff were new in post and had not had safeguarding training since starting work at the practice. The safeguarding policy also needed to be updated to show who was the safeguarding lead. At this inspection in December 2021 we saw all staff had completed safeguarding training at a level appropriate to their role and there was a named safeguarding lead in place.</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At the August 2019 inspection we saw there were gaps in the recruitment records. We saw no evidence of checking photographic ID, and there were staff records where no references had been obtained before the staff members had taken up their posts. Staff vaccination status had also not been recorded. In December 2021 we saw that the recruitment process was now carried out in accordance with regulations.</li> </ul>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2021	Y
There was a fire procedure.	Y
Date of fire risk assessment: 18/10/2021 Actions from fire risk assessment were identified and completed.	Y

## **Infection prevention and control**

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

	<b>Y/N/Partial</b>
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: 26/10/2021	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
Explanation of any answers and additional evidence:	

- We saw that infection control audits and cleaning checklists for individual rooms were in place.

## 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 systems for the appropriate and safe use of medicines, including medicines optimisation**

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items	0.75	0.75	0.69	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)				
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)	7.3%	4.9%	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)	3.32	5.53	5.38	Significant Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	55.4‰	150.5‰	126.1‰	Variation (positive)
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)	0.44	0.66	0.65	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.	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.	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

Medicines management	Y/N/Partial
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> <ul style="list-style-type: none"> <li>At the last inspection in August 2019 the practice was not monitoring the movement of blank prescription stationary through the practice. In December 2021 we saw that a system was now in place to log prescription stationary when it came into the practice and when it was moved between rooms. We were told that prescription stationary was taken out of printers each night and stored in a locked cupboard within a locked room.</li> <li>Changes had been made to ensure the cold chain was effectively monitored. Temperatures of refrigerators storing medicines were checked daily and a data logger had been installed so the practice could ensure the thermometers on the refrigerators were working correctly.</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.	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:	9
Number of events that required action:	7
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We saw a system was in place to raise and review significant events. Staff we spoke to were able to describe the process and told us they received feedback when things went wrong and changes were made. We saw minutes of meetings where significant events were discussed, however the documentation related to significant events was limited on detail and did not fully describe the learning that had been taken from the event.</li> </ul>	

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

Event	Specific action taken
Computer system froze, meaning data could not be inputted.	Audits are now carried out whenever there is a computer system failure to ensure that all data that should have been entered on to a patient's record is on there.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At the inspection in August 2019 we saw that the system to receive, review, and disseminate safety alerts in the practice required improvement. At this inspection we saw that improvements had been made and safety alerts were now reviewed and logged by the practice manager. We saw examples of actions taken on recent alerts. However, there were still some improvements which could be made, for example the system did not always allow the practice manager to know that alerts they sent out had been received and read, and only those alerts which were deemed to require action were kept by the practice. We were told that the practice would put read receipts on emails when alerts were sent out and would log all safety alerts into the practice from now on.</li> </ul>	

## Effective

## Rating: Good

At the last inspection in August 2019 the practice was rated as requires improvement for effective care as improvements were needed in a number of areas, such as the care and treatment for patients who needed regular reviews, the monitoring of patients on high-risk medications, and training of staff. At this inspection, while we saw that there were still areas where further work was required, such as gaps in training and monitoring of patients on high risk medications, improvements had been made and the practice is now rated as good for effective care.

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

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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"><li>At the inspection in August 2019 we saw that there were no recorded blood test results for patients who were on high risk medications. At this inspection in December 2021 we saw that</li></ul>

in most cases, patients who were prescribed high risk medications were appropriately monitored, but there were some areas where improvements were needed. For example, of 55 patients on Novel Oral Anticoagulants (NOACs), 51 did not have results for all of the required blood tests documented in the record. The practice gave us reasons why they believed these tests had either not been carried out or did not have results showing on their system, such as patients feeling reticent to attend the practice for tests due to Covid-19, but these reasons were not clearly documented on the patient records.

- 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.
- 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.
- 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. However, during a review of the practice's computer system we saw there were five patients who met the criteria for a diagnosis of diabetes which had not been given one.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	18	24	75.0%	Below 80% uptake
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)	25	32	78.1%	Below 80% uptake
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)	25	32	78.1%	Below 80% uptake
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)	25	32	78.1%	Below 80% uptake
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)	39	46	84.8%	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

We asked about the rates of childhood immunisation and the practice were aware they were below target and were taking steps to try and increase uptake. We were told that a high percentage of the practice list was Polish (approx. 30%) and that they knew from talking to patients that many of these children returned to Poland to have their immunisations. The practice had taken steps to try and improve uptake, such as producing leaflets in Polish and using Polish-speaking staff to try and encourage patients to have their children immunised at the practice.

No formal audit of the reasons for low immunisation rates had been carried out to look to confirm these factors or to look for additional ones, but the practice was able to show that in their most recent unverified data, of 17 children who had not attended for immunisations across all age groups, 15 were Polish. This data also showed that there had been improvements in uptake in some areas since measures had been introduced to encourage patients to attend. For example, we saw that 27 out of 31 children under two had attended for their MMR vaccine (87%).

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	67.7%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	67.9%	70.3%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	66.8%	60.1%	63.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	64.3%	50.0%	54.2%	No statistical variation

#### Any additional evidence or comments

We asked about the cervical screening rates and the practice were aware they were below target and were taking steps to try and increase uptake. They told us the rate was lower than it had been previously due to patient concern about attending the practice during the Covid-19 pandemic. They also said they had struggled to encourage some of the practice's Polish population to attend due to their preference to return to Poland for screening. To tackle this, the practice had worked with the CCG to look for ways to improve uptake. We saw the practice had created information leaflets in Polish and used Polish-speaking staff to contact Polish patients who did not attend to try and encourage them to do so. They had also put on a cervical screening clinic in an attempt to make it easier for patients to make appointments.

While the practice believed these to be the reasons for low attendance from anecdotal evidence, no formal audit of the reasons for low screening rates had been carried out to confirm these factors or to look for additional ones. However, the practice was able to show that 90% of patients who did not attend for cervical screening were Polish, and that since putting the above measures in place their cervical screening rates had improved. Unverified Quality and Outcomes Framework (QoF) data for 2021/22 showed their cervical screening rate was currently at 81%.

## 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

<ul style="list-style-type: none"><li>• An audit of patients on Proton Pump Inhibitors (medication to protect the gastric system) was carried out to ensure that nobody was prescribed both Clopidogrel and Omeprazole, due to the interaction this can cause. No patients were found to be prescribed both medications each time the audit was run. It was due to be run again in January 2022.</li><li>• An antibiotic prescribing audit was carried out to ensure antibiotics were being prescribed in line with guidance. The audit identified patients who needed to be reviewed, however the report we saw did not detail whether or not this had been done. We did, however, see data that showed antibiotic prescribing was within target.</li><li>• An audit of inhaler use in COPD patients found that the practice had not been following local guidelines. This was corrected as a result of the audit and affected patients were invited to the practice for a review.</li></ul>
---

## 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.	Partial
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician	Y

associates.	
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"> <li>At the inspection in August 2019 we saw that the practice induction was completed verbally and was not written down. In December 2021 we saw that a formal induction was now in place and was documented. Staff we spoke to were able to describe the induction process to us.</li> <li>In August 2019 the process for staff appraisals was not yet in place but this had been started by December 2021, and all staff who had been there longer than 12 months had had an appraisal.</li> <li>In August 2019 there was no process for checking professional competence and qualifications of clinical staff, but this was in place when we inspected the practice in December 2021.</li> <li>In August 2019 there was no training plan in place for the practice. We saw that this had been implemented in December 2021 and most staff had completed their mandatory training in line with the practice's training plan. However, there were some gaps in the training matrix where it was unclear if training had been completed. For example, the training plan stated that basic life support training should be annual for clinical staff, but there was no record of it having been completed for the practice nurse and the last entry for the GP was in 2019. The practice stated that there had been some difficulty in accessing face-to-face training for staff due to the pandemic, however there were some areas (such as fire safety) where it had been recorded that some staff had carried out the training but others had not. We were also told the practice nurse also worked at another practice where they completed most of their training, however only some of the training had been documented on the training matrix.</li> </ul>	

## 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

## 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.	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"><li>We discussed the demands on the lead GP as the sole doctor at the practice. He told us he was aware of this and actively managed his time to try and protect his wellbeing as well as possible.</li></ul>	

### 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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>There were some gaps in the training matrix, but the majority of staff had completed equality and diversity training in the past 18 months.</li> </ul>	

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

Source	Feedback
Staff interviews	Staff we spoke to told us they felt supported by the leadership at the practice. They said leaders were approachable and that they felt comfortable to raise concerns with them.

### 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

### 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.	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.	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

## 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
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
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	Y

video and voice call services.	
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:	
<ul style="list-style-type: none"> <li>We were told that the Patient Participatient Group (PPG) was not meeting currently due to Covid-19.</li> </ul>	

## 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

- Since the last inspection in August 2019, the practice had made multiple improvements, including improving the recruitment processes, putting more robust processes in place to safely store prescription stationary, improving the system for disseminating safety alerts, updating policies, and improving the management of the cold chain.
- The process for handling complaints had been improved since the last inspection in 2019. In December 2021, information was readily available for patients about how to make a complaint, and this included information on how to complain to the Parliamentary and Health Service Ombudsman (PHSO), which had not been the case in 2019.
- There was a programme of audit which had led to measurable improvements for patients at the practice.
- Practice staff had created resources in languages other than English to try and encourage patients whose first language was not English to attend for screening and to signpost them to other health services in the area.

## 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 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.
- 
- $\text{‰}$  = per thousand.