

# Care Quality Commission

## Inspection Evidence Table

### Moseley Medical Centre (1-9586372875)

Inspection date: 13 December 2022

Date of data download: 10 November 2022

**Overall rating: Good**

**Safe**

**Rating: Good**

#### Safety systems and processes

**The practice had 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.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>The practice had named clinical and administrative safeguarding leads for managing safeguarding concerns and staff knew who they were if they needed to raise a concern or for support in this area.</li><li>Staff had access to safeguarding policies and procedures that were reviewed annually.</li><li>The safeguarding registers were reviewed regularly to ensure they were kept up to date and patients were followed up as appropriate. We saw evidence of this in our review of clinical records and the minutes of the monthly safeguarding meetings with the health visitor.</li><li>Training records seen showed that staff were up to date and trained in safeguarding children and adults to an appropriate level for their roles and responsibilities.</li></ul>	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> <li>We saw that alerts were used on the clinical system so that staff were aware of any patients that may be at risk of harm.</li> <li>Disclosure and Barring Service (DBS) checks were undertaken for staff and we saw evidence of this in the sample of records we reviewed. DBS checks identify whether a person has a 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.</li> <li>Records seen showed that staff who acted as chaperones had received relevant training and were DBS checked.</li> <li>The practice staff had been IRIS (Identification and referral to improve safety) trained to support those at risk of domestic violence.</li> </ul>	

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.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>We reviewed the recruitment files for two members of staff and found appropriate checks had been carried out on recruitment.</li> <li>Information about staff immunisations was available, records seen covered most of the immunisations recommended for staff working in healthcare settings. However, no risk assessments were in place where a recommended immunisation was absent.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 3 June 2022	Y
There was a fire procedure. Date of fire risk assessment: 12 May 2022	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice shared with us a range of health and safety policies and risk assessments that were in place to support staff.</li> <li>Training records showed that staff had undertaken and were up to date with health and safety and fire safety training. The practice's nominated fire wardens had also undertaken additional training for the role.</li> <li>We saw that the practice's fire procedure was displayed throughout the practice.</li> <li>The fire risk assessment undertaken showed limited actions required with the practice having appropriate safety measures in place.</li> <li>There were risk assessments in place for the Control of Substances Hazardous to Health (COSHH), where COSHH products were used within the practice.</li> </ul>	

- We saw that fire equipment had been serviced in the last 12 months, regular checks of fire alarms and six-monthly fire drills were also undertaken to ensure staff knew what to do in the event of a fire.
- Records seen showed that clinical equipment had undergone portable appliance testing for electrical safety and calibration to ensure they were working properly within the last 12 months.

## 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: 4 November 2022	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:	
<ul style="list-style-type: none"> <li>• We found the practice to be visibly clean and tidy during our onsite visit to the practice.</li> <li>• Staff had access to infection prevention and control (IPC) policies and training. Records seen showed most staff were up to date with their IPC training.</li> <li>• There was a nominated infection control lead to support staff.</li> <li>• Cleaning was carried out by an external cleaning company who undertook cleaning audits.</li> <li>• We saw that staff had access to personal protective equipment and wipes to clean between patients. There were spill kits in place for the cleaning of any bodily fluid spills.</li> <li>• Cleaning logs were maintained in each of the clinical rooms for the routine cleaning of clinical equipment and workspace.</li> <li>• The practice had recently undertaken an IPC audit which had scored 99%. Staff were able to tell us of actions taken from previous audits which included the replacement of chairs so that they could be cleaned more effectively. The practice had also carried out a hand hygiene audit with staff.</li> <li>• The practice had appropriate arrangements for the removal of clinical waste including sharps.</li> <li>• Reception staff we spoke with were able to tell us how they safely handled clinical specimens.</li> <li>• A legionella risk assessment had been carried out at the practice in September 2021 which rated the practice as low risk. The practice carried out routine flushing of water outlets and temperature checks to safeguard against legionella.</li> </ul>	

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was a staff rota in place to ensure tasks were covered on a daily basis.</li> <li>• Administrative / reception staff were trained in multiple tasks so that they could support each other during absences.</li> <li>• The practice currently had vacancies within the administrative team but were in the process of recruiting new staff to them.</li> <li>• There was an induction pack for locum staff working at the practice on a temporary basis and staff told us that relevant information was discussed with the locum on their arrival.</li> <li>• Staff received training in basic life support and sepsis, there were posters displayed throughout the practice raising awareness of sepsis.</li> <li>• Staff knew where to find the emergency equipment when needed.</li> </ul>	

## 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. <sup>1</sup>	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Our review of the practice's clinical system found workflow was managed in a timely way.</li> <li>• Test results were reviewed by the GPs and there was a daily rota for this. This enabled the practice to ensure test results were reviewed if one of the GPs was absent.</li> <li>• The practice had a dedicated member of staff for summarising new patient notes.</li> <li>• The practice maintained a log of patients referred on the two week wait cancer referral pathway. We found the log was reviewed to check patients were followed up.</li> </ul>	

## 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)	0.65	0.82	0.82	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). (01/07/2021 to 30/06/2022) (NHSBSA)	7.7%	7.8%	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 prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.13	5.18	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	62.1‰	113.6‰	128.0‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.44	0.61	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	9.9‰	7.8‰	6.8‰	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

Medicines management	Y/N/Partial
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 effective medicines reviews for patients on repeat medicines. <sup>1</sup>	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. <sup>2</sup>	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
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
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li>• As part of our inspection we looked at the management of medicines through clinical searches and reviews of a sample of patient records. We found the practice was managing patients' medicines safely. For example: <ul style="list-style-type: none"> <li>○ Our searches identified 3 patients on Disease-modifying antirheumatic drugs (DMARD) which have the potential for serious side effects. DMARDs are commonly used to treat inflammatory conditions such as rheumatoid arthritis. We found all 3 patients were receiving the required monitoring and blood tests.</li> <li>○ Our searches identified 2 out of 173 patients on a high-risk medicine used to treat heart conditions and high blood pressure that were overdue their monitoring. These medicines also require regular monitoring due to the risk of side effects. We reviewed both records and found no concerns with the management of these patients.</li> <li>○ Our searches identified 10 patients on a medicine commonly used to treat conditions such as epilepsy and nerve pain that had not received monitoring in the last 12 months.</li> </ul> </li> </ul>	

Medicines management	Y/N/Partial
<p>This medicine can be addictive and pose risks to unborn babies. We reviewed the records for five of these patients and found appropriate management in place.</p> <ul style="list-style-type: none"> <li>○ We reviewed 5 medicine reviews undertaken by clinical staff in the last three months and found these were all appropriately recorded.</li> </ul> <ul style="list-style-type: none"> <li>● National prescribing data showed practice prescribing was in line with other practices locally and nationally.</li> <li>● The practice was supported by two pharmacists from their primary care network (PCN) who were involved in undertaking medicine reviews and ensuring patients received appropriate follow up and monitoring. The practice carried out monthly audits of their consultations and prescribing competence.</li> <li>● We saw that emergency medicines and equipment were available. These were checked regularly to ensure they were available, in date and fit for use.</li> <li>● There were appropriate arrangements in place for managing the cold chain to ensure vaccines were fit for use.</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:	14
Number of events that required action:	14
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>● Staff we spoke with knew how to report incidents and significant events and were able to share examples of learning from them.</li> <li>● We saw from the minutes of practice meetings that incidents were a standing agenda item and were discussed with staff to support learning and improvement.</li> </ul>	

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

Event	Specific action taken
Cold chain breach. The medicine fridge temperature had not been reset when new stock had been placed in the fridge.	<ul style="list-style-type: none"> <li>• Training issue identified. The practice nurse retrained all staff on checking and resetting the fridge temperature. The training of new staff was to be undertaken by the practice nurse only.</li> <li>• Advice sought from the vaccine manufacturers'.</li> <li>• Vaccines were discarded.</li> <li>• Incident discussed with staff in the practice meetings.</li> </ul>
Patient attended the practice following a text message to collect paperwork for a referral but did not know what the referral was for.	<ul style="list-style-type: none"> <li>• Decision made to call patients as well as text when undertaking tasks to avoid confusion.</li> <li>• Incident discussed with staff in the practice meetings.</li> </ul>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The PCN pharmacist took the lead on managing and acting on patient safety alerts such as those from the Medicines and Healthcare products Regulatory Agency (MHRA). Relevant safety alerts were discussed at the clinical meetings to raise awareness among staff.</li> <li>• As part of our inspection and clinical searches we reviewed action taken by the practice in response to a MHRA alert. The MHRA alert related to a medicine which should not be given to female patients of childbearing age due to the risk to unborn babies. We reviewed the records of 5 patients of childbearing age on these medicines, records showed that the risks had been discussed with the patient.</li> </ul>	



## Effective

## Rating: Requires Improvement

**We have rated the practice as requires improvement for providing effective services due to the low uptake of child immunisation and cervical screening.**

*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. <sup>1</sup>	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	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"><li>• Our review of a sample of clinical records found appropriate monitoring and follow up was in place for patients with or at risk of developing long-term conditions.</li><li>• The practice used their monthly clinical meetings to discuss safety updates, new clinical guidelines and any complex cases.</li></ul>	

### 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. The practice advised that they had carried out 113 NHS Health checks in the last year.
- Patients with a learning disability were offered an annual health check. The practice advised that the uptake of learning disability reviews was at 84% in the last year.
- 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.
- People who misused substances were signposted to local services available to meet their needs.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The practice had implemented changes to try and improve the uptake of mental health reviews, this included longer appointments and holding mental health events at the practice.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- The practice had systems in place for recalling patients with long-term conditions to attend for their 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. For example, the practice was supported by diabetes specialist nurse.
- Our review of a sample of clinical records found appropriate monitoring and follow up was in place for patients with long term conditions. For example:
  - Our clinical searches found 1 patient with the potential for a missed diabetes diagnosis based on blood results. We found the patient had been appropriately coded and followed up.
  - Our clinical searches found no patients at risk of a missed diagnosis of chronic kidney disease based on blood results.
  - Our clinical searches identified 10 out of the 180 patients on the asthma register that had been prescribed 2 or more courses of rescue steroids in the last year (an indication of poor asthma control). We reviewed 5 of the records and found all patients had received appropriate assessment and follow up of their condition.
  - Our review of 5 patients with hypothyroidism showed all had received appropriate follow up within the last 18 months.
  - Our clinical searches identified 12 out of 187 patients on the diabetes register with diabetic retinopathy (eye complications) who had blood test results that indicated poor diabetic control. We reviewed a sample of 5 records and found all patients had received appropriate monitoring and follow up.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

- The practice 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.
- Patients with suspected hypertension were asked to undertake home blood pressure monitoring.
- 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, 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)	23	27	85.2%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	19	28	67.9%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	20	28	71.4%	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)	20	28	71.4%	Below 80% uptake
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)	16	23	69.6%	Below 80% uptake

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

### Any additional evidence or comments

- The most recently published data showed that the practice was not meeting the minimum uptake target of 90% for any of the childhood immunisation indicators or the World Health Organisation (WHO) uptake

target of 95% (the recommended standard for achieving herd immunity) for 4 of the 5 childhood immunisation indicators between April 2020 and March 2021.

- Trends in childhood immunisation uptake showed there had been improvement in the uptake of immunisations given at age 1, but little change in the uptake at age 5 and a decline in those given at age 2.
- Staff told us that there was a nominated member of staff that contacted the parents or guardians of children for their immunisations and those who failed to attend were discussed with the health visitor.
- Following the inspection, the practice shared with us a copy of their action plan to try and improve the uptake of immunisations which showed that work was in progress. They also shared with us unpublished/unvalidated data showing an improved picture of uptake for 2021 to 2023 however, the data provided was not directly comparable to derive any specific conclusions.

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 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)	58.7%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	45.9%	52.5%	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)	48.5%	55.5%	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)	50.0%	52.9%	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"> <li>The practice was significantly below the national target of 80% for the uptake of cervical cancer screening. There had been little change in the trends in uptake over the past few years.</li> <li>Staff advised that the administrative team supported the recall of patients and that they had started to use personalised text messaging to try and encourage uptake. Following the inspection the practice shared with us their action plan for improving the uptake of cancer screening programmes which included actions such as identifying an administrative lead for call and recall who discussed progress with the practice manager on a weekly basis and actions to improve the availability of sample takers.</li> <li>At the time of inspection there was limited practice nurse availability during the week however the practice nurse worked until 7pm on a Monday to support those that were unable to attend during the day due to working commitments. Following the inspection, the practice told us that some of the GPs supported with the cervical screening to improve the availability of appointments to patients.</li> <li>Practice data although not directly comparable to that of the UK Health Security Agency showed the practice had screened 71% of eligible patients aged 25-49 years and 81% of eligible patients aged 50 to 64 years since 1 April 2022</li> <li>The practice uptake of other cancer screening programmes (breast and bowel cancer) was below local and national averages. The practice provided evidence following the inspection that they had tried to contact the cancer screening team for additional support to improve uptake.</li> <li>The practice advised us of action they had undertaken to improve the uptake of bowel cancer screening. This included the provision of patient information regarding the purpose of the test and how to undertake it and a monthly follow up by text message to patients issued with a test who had not returned them. An audit showed an improvement in the return rate from 38% (January to May 2022) to 72% (June to October 2022).</li> </ul>

## 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

<p>The practice shared with us clinical audits and quality improvement activities that they had undertaken. These included:</p> <ul style="list-style-type: none"> <li>• An audit of a disease-modifying antirheumatic drug (DMARD) following a safety alert that recommended that the day of week to take the medicine is recorded on the prescription to minimise the risk of overdose. The audit showed improvement in including this information between the first and second audit cycle.</li> <li>• An audit to ensure patients on a medicine combination which increases the risk of hyperkalaemia (high potassium levels) are receiving appropriate monitoring. The audit showed improvement in monitoring within the appropriate timeframe between the first and second audit cycle.</li> <li>• The practice had also undertaken surveys to look at access to identify patient preference for appointments. This had included specific work with patients over the age of 75 years. Appointments had been adjusted following the survey findings.</li> </ul>
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**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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The provider had identified mandatory training requirements for staff and online training was made available to them for this. We reviewed a sample of training records and saw that staff were up to date with their training.</li> <li>• We saw evidence that staff received role specific training for duties they undertook for example, vaccinations and cervical screening.</li> <li>• Staff told us that the practice was supportive of training and development to meet the needs of the service and that they received protected learning time to undertake training.</li> <li>• We saw examples of consultation and prescribing audits undertaken for non-medical clinical staff in advanced roles.</li> <li>• From a sample of records reviewed we saw that staff received annual appraisals which enabled them to discuss any learning and development needs and new staff received induction training.</li> </ul>	

## Coordinating care and treatment

### Staff worked 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice held various multi-disciplinary team meetings to discuss ongoing care needs of some of their most vulnerable patients. These included safeguarding, palliative care and mental health meetings.</li> <li>• The practice was supported by a specialist diabetes nurse, who worked with some of the practice's more complex diabetes patients.</li> </ul>	

## Helping patients to live healthier lives

### Staff were 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice offered NHS health checks, which enabled them to identify any health risks and provide appropriate support and guidance to patients.</li> <li>• Patients at risk of developing diabetes were referred to the national diabetes prevention programme.</li> <li>• The practice referred or signposted patients to services offering lifestyle support including smoking cessation.</li> <li>• Through the PCN, the practice was also able to provide patients with social prescribing and mental health support. They were also able to obtain support from a dietitian.</li> <li>• The practice had undertaken various events to support and educate patients with regard to their health needs, these have included mental health and mindfulness events.</li> </ul>	

## Consent to care and treatment

### The practice 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. <sup>1</sup>	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff had access to policies relating to consent and the Mental Capacity Act.</li> </ul>	



- Clinical staff we spoke with understood the requirements when assessing capacity and in relation to child consent.
- As part of the inspection we reviewed three records where DNACPR decisions had been recorded. We found the rationale for the decision had been clearly documented and that the decision had been discussed with the patients whose views had been sought and respected.

## Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from the national patient survey was above local and in line with national averages.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Discussions with staff demonstrated that they had an understanding and awareness of the importance of person-centred care.</li><li>• The practice had run events to support patients with poor mental health.</li><li>• Staff received training in equality and diversity.</li></ul>	

Patient feedback	
Source	Feedback
NHS website	There were 5 reviews left on the NHS Website in the last 12 months, all were positive with comments made about helpful and friendly staff and caring doctors.
Google reviews	The practice was rated 2.2 out of 5 stars based on 61 goggle reviews. There were 10 reviews made in the last 12 months, positive comments related to friendly, helpful and professional staff whereas negative comments related mainly to access.
Patient feedback	There was positive feedback about the staff.

## National GP Patient Survey results

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
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	85.5%	80.4%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	83.2%	78.5%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	94.9%	90.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	83.6%	65.0%	72.4%	No statistical variation

### Any additional evidence or comments

Results from the latest GP National Patient Survey (published in July 2022) were above local and in line with national averages for questions relating to patient experience.

### Question

The practice carries out its own patient survey/patient feedback exercises.

Y/N

Y

### Any additional evidence

The practice had carried out their own inhouse patient surveys which focused on access. They also surveyed patients over 75 years to obtain their opinion on the quality of care received to identify areas for improvement.

## Involvement in decisions about care and treatment

### Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Results from the GP National Patient Survey (published in July 2022) were above local and national averages for questions about involvement in decisions.</li> <li>Patients requiring additional support needs could be referred to the social prescriber employed through the PCN.</li> </ul>	

Source	Feedback
On-line feedback (NHS and Google reviews)	Patients did not report any concerns with staff involving them in decisions about their care and treatment.

### National GP Patient Survey results

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
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	91.4%	86.3%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice had a range of information available for patients to take away in the waiting area.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 46 patients as carers (approximately 1.4% of the practice population)
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>The practice had a nominated carers champion to support patients who were carers.</li> <li>Patients who identified themselves as carers were offered health checks and flu vaccinations. They were referred and signposted to support available, including social prescribing.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>Patients who were bereaved were sent a text message advising of support available and to send condolences to the family.</li> </ul>

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Staff were aware that they could take patients to an available room if the patient wished to speak privately.</li> </ul>	

# Responsive

Rating: Good

Responding to and meeting people's needs

## The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had undertaken a survey with patients over 75-year olds to better understand the service from their perspective. Changes were made as a result of the survey including more face to face and home visits.</li> <li>The practice carried out routine home visits to support their older vulnerable patients. Home visits were supported by the PCN paramedic.</li> <li>The practice provided longer appointments for those with specific needs for example, those with poor mental health or learning disabilities.</li> <li>The practice was a converted house that had been adapted to provide primary medical services. There was ramp access through a side entrance to enable patients who used wheelchairs or had mobility difficulties to more easily access the service.</li> <li>The practice had disabled toilet facilities and baby changing facilities for patients to use.</li> <li>The practice made use of translation services when needed and there was a notice in reception in different languages to help staff identify the language needs of those who did not speak English.</li> <li>There was a hearing loop available for those who were hard of hearing.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm In house extended access appointments available until 7.10pm with a GP or Nurse
Tuesday	8am to 6.30pm In house extended access appointments until 7.30pm with a GP
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm

Friday	8am to 6.30pm
Appointments available:	
Monday	9am to 12 noon and 4.30pm to 6.30pm
Tuesday	9am to 12 noon and 4.30pm to 6.30pm
Wednesday	9am to 12 noon and 4.30pm to 6.30pm
Thursday	9am to 12 noon and 4.30pm to 6.30pm
Friday	9am to 12 noon and 4.30pm to 6.30pm
Extended access hub appointments were also available at various other local surgeries	Monday to Friday – 6.30pm to 8pm Saturday – 9am to 4pm Sunday – 12 noon to 3pm

### Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school.
- The practice was open until 7.10 pm on a Monday and 7.30pm on a Tuesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a PCN. Appointments were available in the evening and at weekends.
- The practice held registers of patients living in vulnerable circumstances for example, those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. The practice operated a safe surgery in which patients could register without proof of address or identity.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Patients with a learning disability were allocated longer appointments to accommodate their needs.

### Access to the service

#### People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y

The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y

Explanation of any answers and additional evidence:

- Patients could access appointments by telephone, in person or through an online appointment request.
- Patients who preferred to have a face to face appointment were able to receive one.
- Appointments with a GP were generally on the day but patients could book up to 2 weeks in advance if they wanted to.
- Urgent appointment slots were available on a daily basis. Staff told us that if these were full they would let the GP know.
- The practice was supported by a paramedic through their PCN with home visits.
- The practice manager advised that they checked telephone logs where patients had not been able to get through and would call back if the numbers corresponded with a vulnerable patient.



## National GP Patient Survey results

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
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 (01/01/2022 to 30/04/2022)	83.3%	N/A	52.7%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	72.5%	47.4%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	68.6%	47.2%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	72.1%	67.1%	71.9%	No statistical variation

### Any additional evidence or comments

- Results from the GP National Patient Survey (published in July 2022) showed responses to questions about access were above local and national averages.
- The practice had carried out inhouse surveys and had used feedback from these to make changes to improve access to patients. This included information about patient preferences for face to face and telephone calls.

Source	Feedback
Patient online feedback and representatives from the Patient Participation Group (PPG)	While we found comments about the practice were largely positive, there were some negative comments relating to access.

## Listening and learning from concerns and complaints

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

<b>Complaints</b>	
Number of complaints received in the last year.	5
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	<b>Y/N/Partial</b>
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• There was a complaints leaflet and information on the practice website which advised patients how to raise a complaint.</li> <li>• Complaints were discussed as a standard agenda item at practice meetings to support learning and improvement.</li> </ul>	

Example(s) of learning from complaints.

<b>Complaint</b>	<b>Specific action taken</b>
Patient was unhappy with the care they received.	The incident was investigated to review care that had been provided and access to appointments.
Parent request for a vaccination outside the recommended schedule for their child was refused.	Advice sought from Public Health England and vaccination given with risks highlighted.

## 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>• Leaders were aware of the challenges they faced in delivering the service, this included access issues, national medicine shortages and turnover of patients in temporary accommodation.</li><li>• The practice had sought to address those challenges through patient engagement and reviewing access and the skill mix of the practice.</li><li>• The practice was part of a healthcare federation and PCN which enabled them to provide a wider range of services for their patients.</li><li>• Staff we spoke with told us that the leadership of the practice (both clinical and managerial) were very visible and approachable.</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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• Although the practice strategy was not formally documented, the practice leadership had ambitions for the practice including expanding the GP workforce and becoming a training practice for GPs.</li><li>• Staff were aware of the practice vision and values and were working to improve access for their patients, in particular for their vulnerable patients.</li></ul>	

## 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"> <li>• Staff spoke positively about the culture of the practice and the support they received.</li> <li>• Staff told us that they felt able to raise concerns with leaders. There was a whistle blowing policy in place to support staff to raise concerns and a named Freedom to Speak Up Guardian who was independent from the practice.</li> <li>• Staff understood the requirement of the duty of candour and gave examples where they had apologised to patients when things had gone wrong.</li> </ul>	

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

Source	Feedback
Staff interviews	Staff we spoke with told us that Moseley Medical Centre was a good place to work and that everyone was approachable and supportive of each other.

## 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:	

- Staff we spoke with were clear about their roles and responsibilities. Non-clinical staff were trained across various roles so that they could support each other when needed.
- Staff had access to policies and procedures that were regularly updated.
- There were clear meeting structures in place that were inclusive of all staff and ensured important information was shared throughout the practice team. Minutes of meetings were available for those who were unable to attend the meetings.
- The practice advised that during the pandemic they tried to continue with long-term condition and medicine reviews as much as possible by telephone and those at risk were prioritised.

## 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Clinical and staff meetings were the main forum for discussing and managing risks, issues and performance. These were regular agenda items for discussion.</li> <li>We saw a range of risk assessments in place in relation to the management of the premises.</li> <li>The practice had a disaster recovery plan which was accessible to staff from their computers. This set out the arrangements in the event of a disruption to the running of the service. Copies of the plan were kept off site should the premises become inaccessible.</li> </ul>	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	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"> <li>Data was used to monitor and improve performance with systems in place for regular clinical searches in areas such long term conditions and medicine management.</li> <li>The systems in place to monitor performance had been embedded, this was supported by the findings of our clinical searches and reviews of patient records.</li> </ul>	

## 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"> <li>• We saw evidence that the practice was registered with the Information Commissioner's office.</li> <li>• Staff had access to policies and training relating to information governance.</li> <li>• There was information on the practice website as to how patient information was used and shared.</li> <li>• There was a remote working policy in place to support staff as to how they should be working to ensure confidentiality.</li> <li>• Staff told us that when they spoke to patients remotely, they asked questions to confirm the patient's identity before sharing any information.</li> <li>• Online services were accessible to patients through a secure login and password.</li> </ul>	

## 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
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Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice utilised information from patient surveys, the friends and family test and patient participation group (PPG) to help improve the service.</li> <li>• The practice was able to tell us how they had used patient feedback to improve access, for example increasing clinical staffing and making changes to appointments to meet patients' preferences and needs.</li> <li>• There was an active PPG that met on a quarterly basis. In response to feedback from the PPG the practice had implemented a dedicated board in the waiting area for sharing information. Minutes seen showed discussions about what was happening in the practice.</li> <li>• The practice had undertaken a staff survey during 2022. Results from the survey were positive about working at the practice.</li> <li>• Staff told us they had opportunities to raise suggestions and give feedback through the regular staff meetings and appraisal processes.</li> <li>• The practice engaged with their local PCN; a group of local GP practices that work together to address local priorities.</li> </ul>	

#### Feedback from Patient Participation Group.

#### Feedback

We spoke with representatives from the practice's PPG, who told us that they had regular meetings. We received mixed feedback from them in relation to the service and access to appointments.

#### Continuous improvement and innovation

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

	Y/N/Partial
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There was a strong focus on continuous learning and improvement.	Y
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Learning was shared effectively and used to make improvements.	Y
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Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Staff had access to training. They received regular appraisals and supervision and were supported in their professional and personal development.</li> <li>• The practice undertook clinical audits to improve prescribing safety.</li> <li>• Patient feedback was sought and used to develop an appointment system that was flexible and supported those who were most vulnerable to access services.</li> <li>• The practice had run various patient events to support and signpost patients with poor mental health and dementia.</li> </ul>	



## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

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